

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 11066

County aaVillage or City Parole (No. \_\_\_\_\_)2 FULL NAME Jane AbramSTATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 21

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Black 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married  
(Write the word)

6 DATE OF BIRTH Unknown, 1830  
(Month) (Day) (Year)

7 AGE 84 yrs. Unknown If LESS than 1 day, \_\_\_\_ hrs. OR \_\_\_\_ min. ?  
mos. \_\_\_\_ ds. \_\_\_\_

8 OCCUPATION  
(a) Trade, profession, or particular kind of work At Home  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) md

PARENTS  
10 NAME OF FATHER Sanders Schriener  
11 BIRTHPLACE OF FATHER (State or country): md  
12 MAIDEN NAME OF MOTHER Mary Griffith  
13 BIRTHPLACE OF MOTHER (State or country) md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jas. Abram(Address) Parole

15 Filed Nov 13, 1914 Jms Welch  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 13<sup>th</sup>, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov 13<sup>th</sup>, 1914 to Nov 13<sup>th</sup>, 1914  
that I last saw her alive on Nov 12<sup>th</sup>, 1914

and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH\* was as follows:

Senility  
Several months  
(Duration) yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory (Secondary) Exhaustion  
Gradual (Duration) yrs. \_\_\_\_ mos. \_\_\_\_ ds.  
(Signed) John Ridout, M.D.  
Nov 13<sup>th</sup>, 1914 (Address) Annapolis Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, If not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Davidsonville Md DATE OF BURIAL Nov 16, 1914

20 UNDERTAKER Jas. T. Lee Davidsonville ADDRESS \_\_\_\_\_

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

Approved by U. S. Census and American Public Health Association.]

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative wealthfulness of various pursuits can be known. The question applies to each and every person. Irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death.**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as accidental, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be sketched under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
DEC 7 1914  
BUREAU, V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH		11067		STATE OF MARYLAND	
County <i>Anne Arundel</i>		(48)		CERTIFICATE OF DEATH	
Village or City <i>Churchton</i>		(No. ....)		Registration Dist. No. <i>26</i>	
2 FULL NAME <i>Mary E. Gird</i>				[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <i>Female</i>	4 COLOR OR RACE <i>white</i>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <i>widow</i>			
6 DATE OF BIRTH <i>July 23, 1840</i> (Month) (Day) (Year)					
7 AGE <i>74 yrs. 3 mos. 25 ds.</i> 11 LESS than 1 day, .... hrs. OR .... min. ?					
8 OCCUPATION (a) Trade, profession, or particular kind of work <i>At Home</i> (b) General nature of industry, business, or establishment in which employed (or employer) .....					
9 BIRTHPLACE (State or country) <i>Maryland</i>					
PARENTS					
10 NAME OF FATHER <i>George H. Pembroke</i>					
11 BIRTHPLACE OF FATHER (State or country) <i>Maryland</i>					
12 MAIDEN NAME OF MOTHER <i>Ann Rose Bean</i>					
13 BIRTHPLACE OF MOTHER (State or country) <i>Maryland</i>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <i>Geo. J. Dent</i> (Address) <i>Churchton, Md.</i>					
15 Filed <i>Nov 20, 1914</i> <i>Geo. J. Dent</i> REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <i>Nov 18, 1914</i> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from <i>Jan 1904</i> to <i>Nov 17, 1914</i> that I last saw her alive on <i>Nov 17, 1914</i> and that death occurred on the date stated above, at <i>8 A. m.</i> The CAUSE OF DEATH* was as follows: <i>Arthritis deformans</i> (Duration) <i>10 yrs.</i> .... mos. .... ds. Contributory (Secondary) ..... (Duration) ..... yrs. .... mos. .... ds. (Signed) <i>Geo. J. Dent M. D.</i> <i>Nov 20, 1914</i> (Address) <i>Churchton, Md.</i> *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death ..... yrs. .... mos. .... ds. In the State ..... yrs. .... mos. .... ds. Where was disease contracted, If not at place of death? ..... Former or usual residence..... 19 PLACE OF BURIAL OR REMOVAL <i>St Mary's City Md</i> DATE OF BURIAL <i>Nov 20, 1914</i> 20 UNDERTAKER <i>A. E. Glover</i> ADDRESS <i>Sudley, Md.</i>					
If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.					

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

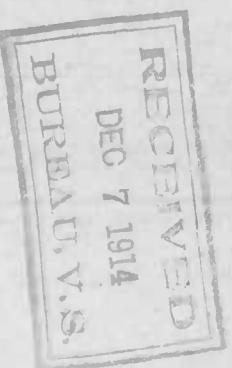
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Taberculo-*  
*sis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Typhoid," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH		STATE OF MARYLAND	
County		CERTIFICATE OF DEATH	
Village or City		Registration Dist. No.	
11068		21	
A.A. County		Annapolis 190 Clay St	
Wesley Belt		St. 3 Ward	
2 FULL NAME			
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)	6 DATE OF DEATH
Male	Colored	married	Nov 24 <sup>th</sup> , 1914
7 DATE OF BIRTH	8 AGE		
Unknown	56 yrs. mos. ds. If LESS than 1 day, hrs. OR min. ?		
9 OCCUPATION			
(a) Trade, profession, or particular kind of work			
Laborer			
(b) General nature of industry, business, or establishment in which employed (or employer)			
Sergeant Pneumonia			
Gradual Exhaustion			
Gradual Heart Failure			
10 BIRTHPLACE (State or country)			
A.A. County			
11 NAME OF FATHER			
Chatham Belt			
12 BIRTHPLACE OF FATHER (State or country)			
A.A. County			
13 MAIDEN NAME OF MOTHER			
unknown			
14 BIRTHPLACE OF MOTHER (State or country)			
unknown			
15 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE			
(Informant) Albert Belt			
(Address) 190 Clay St			
16 Filed Nov 26, 1914 J. S. Welch REGISTRAR			
MEDICAL CERTIFICATE OF DEATH			
17 I HEREBY CERTIFY, That I attended deceased from Nov 18 <sup>th</sup> , 1914 to Nov 24 <sup>th</sup> , 1914			
that I last saw him alive on Nov 24 <sup>th</sup> , 1914			
and that death occurred on the date stated above, at 8:00 PM			
The CAUSE OF DEATH* was as follows:			
Contributory Secondary			
(Signed) John R. Donta, M. D.			
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.			
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)			
At place of death yrs. mos. ds. In the State yrs. mos. ds.			
Where was disease contracted, If not at place of death?			
Former or usual residence			
19 PLACE OF BURIAL OR REMOVAL			
Annapolis neck 26 <sup>th</sup> , 1914			
20 UNDERTAKER			
J. A. Adams Annapolis			

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

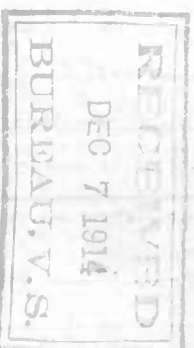
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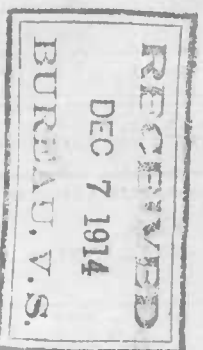
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1 PLACE OF DEATH  
County Anne Arundel

Village or City Annapolis

2 FULL NAME Harry Grafton Boone

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDDED, OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH August 3rd, 1888  
(Month) (Day) (Year)

7 AGE 26 yrs. 3 mos. 9 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work. United R. R. Co. Secret Service Dept.  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Anne Arundel Co. Md.

10 NAME OF FATHER Grafton Boone

11 BIRTHPLACE OF FATHER (State or country) Anne Arundel Co. Md.

12 MAIDEN NAME OF MOTHER Maria P. Reese

13 BIRTHPLACE OF MOTHER (State or country) Anne Arundel Co. Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Grafton Boone

(Address) Annapolis Md

15 Filled Nov 14, 1914 Wm S Welch

REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 21

St. 3rd Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH November 12, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct 19, 1914, to November 12, 1914.

that I last saw him alive on November 12, 1914.

and that death occurred on the date stated above, at 9:00 p m.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis

(Duration) 3 yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed) Walter H. Hopkins, M. D.  
Nov 14, 1914 (Address) Annapolis Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,  
If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Cedar Bluff Cent DATE OF BURIAL Nov 15, 1914

20 UNDERTAKER Gas S. Layton, Son ADDRESS Annapolis



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

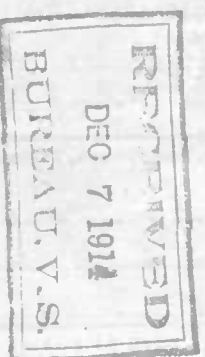
Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plumber*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *10 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH <b>11071</b>		STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Anne Arundel</u> (No. <u>8</u> )		Registration Dist. No. <u>21</u>	
Village or City <u>Salley</u> (No. _____) St.; _____ Ward _____		[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
2 FULL NAME <u>Mary Boase</u>			
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>Female</u>	4 COLOR OR RACE <u>Colored</u>	5 SINGLE, MARRIED, WIDDED, OR DIVORCED <u>Infant</u> (Write the word)	
6 DATE OF BIRTH <u>Sept</u> , 19 <u>14</u> (Month) (Day) (Year)			
7 AGE _____ yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. OR _____ min. ?			
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Infant</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>Infant</u>			
9 BIRTHPLACE (State or country) <u>Maryland</u>			
PARENTS	10 NAME OF FATHER <u>Eli Boase</u>		
	11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>		
	12 MAIDEN NAME OF MOTHER <u>Laura Green</u>		
	13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u>		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Eli Boase</u> (Address) <u>Salley, Md</u>			
15 Filed <u>Nov 20</u> , 19 <u>14</u> <u>Thomas D. Grayson</u> REGISTRAR			
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH <u>Nov</u> <u>19</u> , 19 <u>14</u> (Month) (Day) (Year)			
17 I HEREBY CERTIFY, That I attended deceased from <u>Nov 17</u> , 19 <u>14</u> to <u>Nov 19</u> , 19 <u>14</u> . that I last saw her alive on <u>Nov 17</u> , 19 <u>14</u> and that death occurred on the date stated above, at <u>3:00</u> p. m. The CAUSE OF DEATH* was as follows: <u>Whooping Cough</u> <u>Loose Intestines</u> (Duration) _____ yrs. _____ mos. <u>4</u> ds.			
Contributory Secondary _____ (Duration) _____ yrs. _____ mos. _____ ds.			
(Signed) <u>Thomas D. Grayson</u> , M. D. <u>Nov 20</u> , 19 <u>14</u> (Address) <u>Glen Burnie</u>			
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.			
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, If not at place of death? _____ Former or usual residence _____			
19 PLACE OF BURIAL OR REMOVAL <u>Maryland</u>		DATE OF BURIAL <u>Nov 20</u> , 19 <u>14</u>	
20 UNDERTAKER <u>George Howard</u>		ADDRESS <u>Maryland</u>	

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

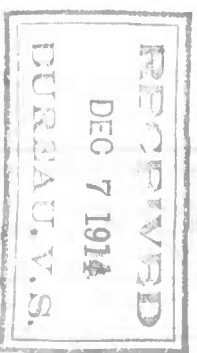
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal, peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory" (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County

Village or City

2 FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,  
MARRIED,  
WIDOWED,  
ORDIVORCED  
(Write the word)

6 DATE OF BIRTH

7 AGE

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER

(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17

I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at 11 a.m.

The CAUSE OF DEATH\* was as follows:

Contributory  
Secondary

(Signed)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

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*oma*, *Sarcoma*, etc., of..... (name origin; "Carcinoma" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *20 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congestant," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 11073

County

Village or City

(No.

Registration Dist. No.

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,  
MARRIED,  
WIDDED,  
ORDIVORCED  
(Write the word)

6 DATE OF BIRTH

7 AGE

If LESS than  
1 day, hrs.  
OR, min. ?

8 OCCUPATION

(a) Trade, profession, or  
particular kind of work

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

9 BIRTHPLACE  
(State or country)10 NAME OF  
FATHER11 BIRTHPLACE  
OF FATHER  
(State or country)12 MAIDEN NAME  
OF MOTHER13 BIRTHPLACE  
OF MOTHER  
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

191

REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17

I HEREBY CERTIFY, That I attended deceased from

that I last saw her alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Contributory  
(Secondary)

(Signed)

(Duration) yrs. mos. ds.  
(Address) Odenton Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT  
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDEN-  
TAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,  
OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or  
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER ADDRESS

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Intuition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECORDED  
DEC 5 1914  
BUREAU. V. S.

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## 1 PLACE OF DEATH

County Anne ArundelVillage or City 3rd District

(No. ...., .....

Registration Dist. No. 21

St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Infant Cook

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH November 7, 1914  
(Month) (Day) (Year)

7 AGE ..... yrs. .... mos. .... ds. If LESS than 1 day, .... hrs. OR .... min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work None  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) A. A. Co., Md.

PARENTS 10 NAME OF FATHER Robert W. Cook  
11 BIRTHPLACE OF FATHER (State or country) A. A. Co., Md.  
12 MAIDEN NAME OF MOTHER Elenor C. Higgins  
13 BIRTHPLACE OF MOTHER (State or country) Maryland.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Robert W. Cook.

(Address) Elvaton, Md.

15 Filed Nov. 7, 1914 J. S. Billingslea  
REGISTRAR

## STATE OF MARYLAND

## 11566 CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH November 7, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from ..... 191..... to ..... 191.....

that I last saw h..... alive on ..... 191.....

and that death occurred on the date stated above, at ..... m,

The CAUSE OF DEATH\* was as follows:

Still-Birth

(Duration) ..... yrs. .... mos. .... ds.

Contributory  
Secondary

(Duration) ..... yrs. .... mos. .... ds.

(Signed) James S. Billingslea, M. D.  
7-13, 1914 (Address) Elvaton, Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. .... mos. .... ds. In the State ..... yrs. .... mos. .... ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Mt. Carmel Church Yard DATE OF BURIAL Nov. 8, 1914

20 UNDERTAKER Armstrong, Denny Co. ADDRESS Balto. Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—[Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automotive factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—[Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Jaundice," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reverber wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

*Send out to be signed by local Reg.*

RECEIVED  
JAN 6 1915  
BUREAU, V. S.

RECEIVED  
FEB 5 1915  
BUREAU, V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

11074

64

STATE OF MARYLAND  
CERTIFICATE OF DEATHCounty A. A. C.Registration Dist. No. 21Villages or City Annapolis (No. Harbors 1711 St.; 1 Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Marcella Courtney Daily

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widow  
(Write the word)

6 DATE OF BIRTH May 14th, 1842  
(Month) (Day) (Year)

7 AGE 72 yrs. 5 mos. 28 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer) Merchant

9 BIRTHPLACE (State or country) Ireland. Co. Meath

PARENTS  
10 NAME OF FATHER Unknown  
11 BIRTHPLACE OF FATHER (State or country) Unknown  
12 MAIDEN NAME OF MOTHER Mary Sullivan  
13 BIRTHPLACE OF MOTHER (State or country) Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) William P. Gordon  
(Address) 111 Harbors St.

15 Filed Nov 11, 1914 Wm. Welch  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH November 9, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 191\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_.

that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 191\_\_\_\_.

and that death occurred on the date stated above, at 7:30 p.m.

The CAUSE OF DEATH\* was as follows:

Apoplexy.

Contributory  
Secondary

(Signed) William F. Minnick, Coroner  
Nov. 9, 1914 (Address) Annapolis, Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL Baltimore Md DATE OF BURIAL Nov 12, 1914

20 UNDERTAKER Geo. J. Taylor ADDRESS Annapolis

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

Ma



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coat making*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faintfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*, *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

11075

County

C.C.

Village or City

Traceys Landing

(No.)

Registration Dist. No.

26

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Hellen Davis

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Colored

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

Nov. 29, 1898

7 AGE

15 yrs. 11 mos. 20 ds.

If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Md

## PARENTS

10 NAME OF FATHER

Edward Davis

11 BIRTHPLACE OF FATHER (State or country)

Md

12 MAIDEN NAME OF MOTHER

Carrie Estep

13 BIRTHPLACE OF MOTHER (State or country)

Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Edward Davis

(Address)

Traceys

15

Filed

Nov. 11, 1914 A. H. Perrie

Local REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Nov. 9, 1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

191

to

191

that I last saw him alive on Oct. 6, 1914

and that death occurred on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 8 mos. 7 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

D. R. Talbot

M. D.

191 (Address) District, Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

M. Hendree, Md

Nov. 11, 1914

20 UNDERTAKER

ADDRESS

Robt. J. Wood

Friendship, Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

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*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Anæmia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY.

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## 1 PLACE OF DEATH

County

U. A.

Village or City

Adelton

(No.

Registration Dist. No.

St.

Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

G. A. Davidson (Darison)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

married

6 DATE OF BIRTH

Nov 22, 1890

(Month)

(Day)

(Year)

7 AGE

34 yrs. 2 mos. 2 ds.

If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

RR Brakeman

(b) General nature of industry, business, or establishment in which employed (or employer)

RR Sec

9 BIRTHPLACE (State or country)

Not Known

PARENTS

10 NAME OF FATHER

Jas B. Davidson

11 BIRTHPLACE OF FATHER (State or country)

Not Known

12 MAIDEN NAME OF MOTHER

Alice Megaw

13 BIRTHPLACE OF MOTHER (State or country)

Not Known

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

H. L. Scott

(Address)

Adelton Md

15

Filed

191

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Nov

22

1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

191 to 191

that I last saw him alive on 191

and that death occurred on the date stated above, at 10 P. m.

The CAUSE OF DEATH\* was as follows:

Struck by RR Engine (accident)

(Duration)

yrs.

mos.

ds.

Contributory (Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

Byron Phelps Jr

M. D.

Nov 22, 1914

(Address)

Adelton Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place

of death

2 yrs.

2 mos.

1 ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted,

If not at place of death?

Same

Former or

usual residence

Well set

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wilmington Del

11/26, 1914

20 UNDERTAKER

ADDRESS

James Chandler

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

Revised from 1512 French St. Private Conveyance Longwood Rd

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1 PLACE OF DEATH 11076

County

A A

Village or City

Annapolis

(No.

Merry Ave

St.;

3 Ward

Registration Dist. No.

21

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Louise Strohm Evans

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

July

17

1903

7 AGE

12

yrs.

3

mos.

17

ds.

If LESS than

1 day,.....hrs.

OR.....min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

School child

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Annapolis Md.

PARENTS

10 NAME OF FATHER

George W. Evans

11 BIRTHPLACE OF FATHER (State or country)

Annapolis Md.

12 MAIDEN NAME OF MOTHER

Martha A. Strohm

13 BIRTHPLACE OF MOTHER (State or country)

Annapolis Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Geo. W. Evans

(Address)

Annapolis Md.

15

Filed

Nov 5, 1914

J. S. Melch

REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Nov 3

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

Oct 1

1914

to

Nov 3 1914

that I last saw her

Nov 2

1914

and that death occurred on the date stated above, at 7:50 a.m.

The CAUSE OF DEATH\* was as follows:

Bright's disease and volume  
disease of heart

(Duration)

yrs.

1

mos.

ds.

Contributory  
Secondary

Dent. Huxon

(Duration)

yrs.

mos.

ds.

(Signed)

Nov 4

1914

(Address)

Geo. W. Evans  
Annapolis Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19 PLACE OF BURIAL OR REMOVAL

St. Annen Cent

DATE OF BURIAL

Nov 5, 1914

20 UNDERTAKER

James S. Lay Jr.

ADDRESS

Annapolis Md.

If more blanks are needed, address State Registrar, 2 E. Franklin St., Balto., Requesting V. S. No. 1.

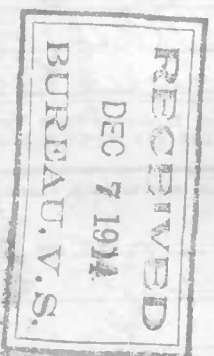
# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

Approved by U. S. Census and American Public Health Association.<sup>1</sup>

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plumber*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory" (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

11077

County

Anne Arundel

8

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

21

Village or City

Severn R. Fd.

(No.)

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

Kenneth C. Franklin

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Infant

6 DATE OF BIRTH

Sept 18, 1914

(Month)

(Day)

(Year)

7 AGE

yrs. 2 mos. 9 ds.

If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Infant

9 BIRTHPLACE

(State or country)

Maryland

## PARENTS

10 NAME OF FATHER

Harry Franklin

11 BIRTHPLACE OF FATHER

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Blanche Franklin

13 BIRTHPLACE OF MOTHER

(State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Edward Franklin

(Address)

Severn R. Fd.

15

Filed

Nov 28, 1914

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Nov 27, 1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

Nov 20, 1914, to Nov 27, 1914.

that I last saw him alive on Nov 27, 1914.

and that death occurred on the date stated above, at 3 P. m.

The CAUSE OF DEATH\* was as follows:

Whooping Cough

(Duration) yrs. mos. 14 ds.

Contributory Secondary

Tobacco

(Duration) yrs. mos. 3 ds.

(Signed)

Thomas W. Brayshaw, M. D.

Nov 28, 1914. (Address) Severn R. Fd.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cedar Hill Cemetery Nov 29, 1914

20 UNDERTAKER

ADDRESS

John Fay Balto

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

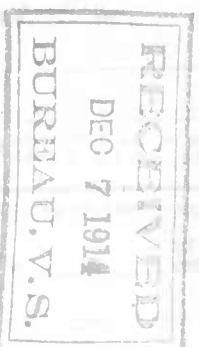
# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con-fertial," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH County <u>Anne Arundel</u>		11078 <u>64</u>		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Annapolis</u>		(No. _____)		St.; _____ Ward _____	
2 FULL NAME <u>Joseph Bonaparte Girault</u>		Registration Dist. No. <u>21</u>			
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Widower</u> (Write the word)			
6 DATE OF BIRTH <u>April 14</u> 18 <u>38</u> (Month) (Day) (Year)					
7 AGE <u>76</u> yrs. <u>6</u> mos. <u>27</u> ds. If LESS than 1 day, ____ hrs. OR ____ min. ?					
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>None</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____					
9 BIRTHPLACE (State or country) <u>Bordentown N. J.</u>					
PARENTS	10 NAME OF FATHER <u>Archie Napoleon Girault</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Lyon, France</u>				
	12 MAIDEN NAME OF MOTHER <u>Margaret S. Wilson</u>				
	13 BIRTHPLACE OF MOTHER (State or country) <u>N. J.</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs. A. J. Munroe</u> (Address) <u>Annapolis Md</u>					
15 Filed <u>Nov 10</u> , 191 <u>4</u> <u>Mrs. Welch</u> REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>Nov. 9</u> , 191 <u>4</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from <u>May 8</u> , 191 <u>4</u> , to <u>Nov. 9</u> , 191 <u>4</u> that I last saw him alive on <u>Nov. 8</u> , 191 <u>4</u> and that death occurred on the date stated above, at <u>3.45 A.</u> m. The CAUSE OF DEATH* was as follows: <u>Apoplexy</u>					
(Duration) yrs. <u>6</u> mos. ds.					
Contributory (Secondary) <u>Arterio-sclerosis</u>					
(Duration) yrs. <u>6</u> mos. ds.					
(Signed) <u>Geo. Wells</u> , M. D. <u>Nov. 9</u> , 191 <u>4</u> (Address) <u>Annapolis Md.</u>					
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds. Where was disease contracted, If not at place of death? _____ Former or usual residence _____					
19 PLACE OF BURIAL OR REMOVAL <u>St Anne Cemetery</u>				DATE OF BURIAL <u>Nov 11</u> , 191 <u>4</u>	
20 UNDERTAKER <u>W. H. Seligman</u>				ADDRESS <u>Annapolis</u>	



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

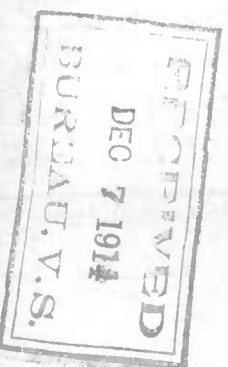
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*oma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Ivanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and quality, as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 11079

County A. A.Village or City Masonville (No. 91)STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 24

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME John Thomas Gleason

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single6 DATE OF BIRTH Feb. 17<sup>th</sup>, 1909  
(Month) (Day) (Year)7 AGE 4 yrs. 9 mos. 9 ds. OR LESS than 1 day, hrs. min. ?8 OCCUPATION  
(a) Trade, profession, or particular kind of work none  
(b) General nature of industry, business, or establishment in which employed (or employer)9 BIRTHPLACE (State or country) Fairfield Md10 NAME OF FATHER Patrick Gleason11 BIRTHPLACE OF FATHER (State or country) Ireland12 MAIDEN NAME OF MOTHER Bessie Thomas13 BIRTHPLACE OF MOTHER (State or country) Prince George's Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Patrick Gleason(Address) Masonville15 Filed Nov 26<sup>th</sup> 1914 J. B. Horton M.D.

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov. 26<sup>th</sup>, 1914  
(Month) (Day) (Year)17 I HEREBY CERTIFY, that I attended deceased from Nov. 19<sup>th</sup>, 1914, to Nov 26<sup>th</sup>, 1914.that I last saw him alive on Nov. 24<sup>th</sup>, 1914.and that death occurred on the date stated above, at 10:30 a.m.

The CAUSE OF DEATH\* was as follows:

Broncho PneumoniaContributory (Duration) yrs. mos. 7 ds.  
Secondary Tonsillitis(Signed) Thomas B. Horton M. D.  
Nov. 26, 1914 (Address) So Baltimore

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL  
Holy Cross Cemetery Nov 28<sup>th</sup>, 191420 UNDERTAKER ADDRESS  
Ges. L. Schwab Bn 2101

If more blanks are needed, address State Registrar, 100 E. Franklin St., Balto., Requesting V. S. No. 1.

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RECEIVED  
DEC 5 1914  
BUREAU, V. S.

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1 PLACE OF DEATH 11080 13-1  
 County A-A-  
 Village or City Annapolis (No. 571 Clay) St. 2 Ward 1  
 Registration Dist. No. 2-1  
 2 FULL NAME William Thomas Green  
 [If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>Colord</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Single</u> (Write the word)
6 DATE OF BIRTH <u>Feb-</u> <u>7</u> , 19 <u>14</u> (Month) (Day) (Year)		
7 AGE <u>8</u> yrs. <u>10</u> mos. <u>10</u> ds. If LESS than 1 day, hrs. OR min. ?		
8 OCCUPATION (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer)		
9 BIRTHPLACE (State or country) <u>A-A- Co Md.</u>		
PARENTS	10 NAME OF FATHER <u>William Thomas Green</u>	
	11 BIRTHPLACE OF FATHER (State or country) <u>A-A- Co Md</u>	
	12 MAIDEN NAME OF MOTHER <u>Rosie Johnson</u>	
	13 BIRTHPLACE OF MOTHER (State or country) <u>A-A- Co, Md</u>	

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Rosie Johnson  
 (Address) 571 Clay St.

15 Nov 19, 1914 Wm J Welch  
 Filed REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 17th, 1914  
 (Month) (Day) (Year)  
 17 I HEREBY CERTIFY, That I attended deceased from Oct 15th, 1914 to Nov 17th, 1914  
 that I last saw him alive on Nov 17th, 1914  
 and that death occurred on the date stated above, at 9 P. m.  
 The CAUSE OF DEATH\* was as follows:

Conventional Debility  
 (Duration) yrs. mos. ds.  
 Contributory (Secondary) Exhaustion  
Gradual (Duration) yrs. mos. ds.

(Signed) John Bidout, M. D.  
Nov 19, 1914 (Address) Annapolis

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 Where was disease contracted, If not at place of death?  
 Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL  
Brewerhill Cemt. 11. 19., 1914  
 20 UNDERTAKER ADDRESS  
E. H. B. Parker & Son 92 West 87

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

Kidout

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faintly employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Scryvni*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Icteric," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*), may be stated under the head of "Contributory" (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.





WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 11571  
 County A.A.  
 Village or City Bridwell (No. 186) St. 2 Ward 2  
 2 FULL NAME Frank Hamilton

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Celoid 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) married  
 6 DATE OF BIRTH Not known (Month) (Day) (Year)  
 7 AGE 46 yrs. — mos. — ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION  
 (a) Trade, profession, or particular kind of work Labourer  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Not known

10 NAME OF FATHER Not known  
 11 BIRTHPLACE OF FATHER (State or country) Not known  
 12 MAIDEN NAME OF MOTHER Not known  
 13 BIRTHPLACE OF MOTHER (State or country) Not known

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) \_\_\_\_\_

(Address) \_\_\_\_\_

15 Filed Nov 30, 1914 Holiday  
 REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 2

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 28, 1914  
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov 23, 1914, to Nov, 1914,  
 that I last saw him alive on Nov 25, 1914

and that death occurred on the date stated above, at 6:30 P. m.

The CAUSE OF DEATH\* was as follows:

Shock from Concussion of the Brain  
 (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 5 ds.

Contributory (Secondary) a blow upon the head  
 (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) B. B. Phelps, M. D.  
Nov 28, 1914 (Address) Odenton, Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Brandywine P. C. DATE OF BURIAL Nov 30, 1914

20 UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

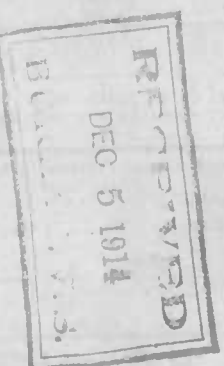
[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death.**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is "indefinite"); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

*oma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## 1 PLACE OF DEATH

County Anne Arundel.

11567

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 21Village or City 3rd district

(No. \_\_\_\_\_)

St.; \_\_\_\_\_ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Joseph B. Harig

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male. 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDDED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH May 15, 1869  
(Month) (Day) (Year)

7 AGE 55 yrs. 5 mos. 18 ds. If LESS than 1 day, \_\_\_\_ hrs. OR \_\_\_\_ min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work Retro Hardware Dealer  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Baltimore. Md.

10 NAME OF FATHER Bernard L. Harig.

11 BIRTHPLACE OF FATHER (State or country) Germany.

12 MAIDEN NAME OF MOTHER Mary Gold.

13 BIRTHPLACE OF MOTHER (State or country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Bernard B. Harig.(Address) Baltimore. Md.

15 Filed Nov. 3, 1914 J. S. Billingsley  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 3, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov 3, 1914. to Nov 3, 1914.

that I last saw him alive on Nov 3, 1914.

and that death occurred on the date stated above, at 7 P. m.

The CAUSE OF DEATH\* was as follows:

Hemorrhage in the Brain.(Duration) Immediate ds.

Contributory Arterio Sclerosis.  
Secondary

(Duration) 4 yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) James S. Billingsley, M. D.  
Nov 3, 1914. (Address) Elvaton. Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Baltimore, Md.

DATE OF BURIAL

Nov 3, 1914.

20 UNDERTAKER

J. J. Fahy.

ADDRESS

Baltimore, Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

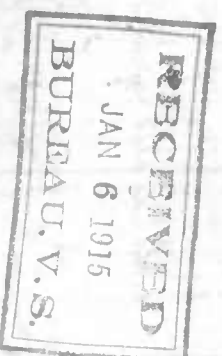
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plaster, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Scutic," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Typhemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 11081

County

Village or City

2 FULL NAME

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH

7 AGE

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

15

Filed

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17

I HEREBY CERTIFY That I attended deceased from

July 1, 1914, to Nov. 27, 1914.

that I last saw him alive on Nov 20, 1914

and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 4 mos. ds.

Contributory Secondary

(Duration) yrs. mos. ds.

(Signed) Thomas B. Lohr, M. D.

Nov 29, 1914 (Address) So Balto

\*State the DISEASE CAUSING DEATH, or, in deaths from violent CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Cedar Hill Cemetery Nov 30, 1914

UNDERTAKER ADDRESS

John J. Fahey Balto



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

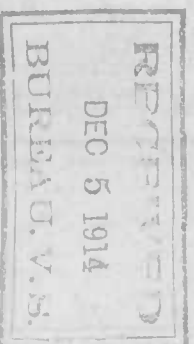
[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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11082

## 1 PLACE OF DEATH

County

Village or City

## 2 FULL NAME

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

Dec. 6, 1897

7 AGE

54 yrs. 11 mos. 3 ds.

If LESS than 1 day, hrs. OR mo. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Laborer in

(b) General nature of industry, business, or establishment in which employed (or employer)

Water department

9 BIRTHPLACE (State or country)

Ireland

## PARENTS

10 NAME OF FATHER

Timothy Lolloran

11 BIRTHPLACE OF FATHER (State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Mary M Sill

13 BIRTHPLACE OF MOTHER (State or country)

Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

M. Baret Lolloran

(Address)

1318 Wilcox St.

15

Filed

Nov 10<sup>th</sup> 1914 J. B. Horton MD

REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Nov. 8, 1914

(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

191 to 191

that I last saw h. alive on 191

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH\* was as follows:

Accidental Drowning

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

James H. Hawley MD

Nov. 191 (Address) Brooklyn, Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

New Cathedral Cemetery Nov 12, 1914

20 UNDERTAKER

ADDRESS

Henry Hock &amp; Son 1301 E. Egan St.

Balto Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
DEC 5 1914  
BUREAU. V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

**1 PLACE OF DEATH** 11083 (79)  
 County a a Camery  
 Village or City Waterbury md (No. \_\_\_\_\_, St.; \_\_\_\_\_ Ward)  
 Registration Dist. No. 21  
 [It death occurred in a hospital or institution, give its NAME instead of street and number.]

**2 FULL NAME** Eleanor V. L. Hopkins

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH	
<b>3 SEX</b> <u>Female</u>	<b>4 COLOR OR RACE</b> <u>White</u>	<b>5 SINGLE, MARRIED, WIDOWED, OR DIVORCED</b> (Write the word) <u>married</u>	<b>16 DATE OF DEATH</b> <u>11</u> <u>5</u> , 191 <u>4</u> (Month) (Day) (Year)	
<b>6 DATE OF BIRTH</b> <u>Sept</u> <u>1</u> , 18 <u>46</u> (Month) (Day) (Year)			<b>17 I HEREBY CERTIFY, That I attended deceased from</b> <u>7-15</u> , 191 <u>4</u> , to <u>11 5</u> , 191 <u>4</u> , that I last saw <u>her</u> alive on <u>11-4</u> , 191 <u>4</u> and that death occurred on the date stated above, at <u>3309</u> m. The CAUSE OF DEATH* was as follows: <u>Myocarditis</u>	
<b>7 AGE</b> <u>18</u> yrs. <u>2</u> mos. <u>5</u> ds. <u>OR</u> <u>min.</u> ? It LESS than <u>1</u> day, <u>hrs.</u>			<b>18 CONTRIBUTORY SECONDARY</b> <u>Cardiac Dilatation</u> (Duration) <u>8</u> yrs. <u>mos.</u> <u>ds.</u>	
<b>8 OCCUPATION</b> (a) Trade, profession, or particular kind of work <u>House Wife</u> (b) General nature of industry, business, or establishment in which employed (or employer)			<b>19 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)</b> At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, It not at place of death? _____ Former or usual residence _____	
<b>9 BIRTHPLACE</b> (State or country) <u>Unknown</u>			<b>20 PLACE OF BURIAL OR REMOVAL</b> <u>Watkins Cemetery</u> DATE OF BURIAL <u>11/8</u> , 191 <u>4</u>	
<b>PARENTS</b>	<b>10 NAME OF FATHER</b> <u>Dr Upton Henry Lawrence</u>	<b>11 BIRTHPLACE OF FATHER</b> (State or country) <u>Unknown</u>	<b>21 UNDERTAKER</b> <u>B. J. Hoppington &amp; Co</u>	
	<b>12 MAIDEN NAME OF MOTHER</b> <u>Mary Jane Childs</u>	<b>13 BIRTHPLACE OF MOTHER</b> (State or country) <u>Unknown</u>	<b>ADDRESS</b> <u>Amelia</u>	
	<b>14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE</b> (Informant) <u>Henry M. B. Hopkins</u> (Address) <u>Waterbury md</u>		<b>15</b> Filed <u>Nov 6</u> , 191 <u>4</u> <u>Wm S Welch</u> REGISTRAR	

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

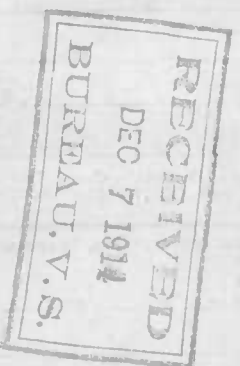
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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or Intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc., State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## 1 PLACE OF DEATH

County Anne Arundel.

11568

19

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 21Village or City 3rd district (No. ....) St.; .... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Emma Lueria Jacobs

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH April 15, 1847  
(Month) (Day) (Year)

7 AGE 66 yrs. 7 mos. 15 ds. If LESS than 1 day, .... hrs. OR .... min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work. House work.  
(b) General nature of industry, business, or establishment in which employed (or employer) retired.

9 BIRTHPLACE (State or country) Anne Arundel Co.

10 NAME OF FATHER Dorsey Jacobs

11 BIRTHPLACE OF FATHER (State or country) Anne Arundel Co.

12 MAIDEN NAME OF MOTHER Charloth Rose

13 BIRTHPLACE OF MOTHER (State or country) Baltimore Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lottie Jacobs(Address) Elkton, Md.

15 Filed Nov 30, 1914 J. S. Bellinger  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH November 30, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July, 1905, to Nov 30, 1914,  
that I last saw her alive on Nov 29, 1914.

and that death occurred on the date stated above, at 10 9 m.  
The CAUSE OF DEATH\* was as follows:

Heart Insufficiency(Duration) 6 yrs. .... mos. .... ds.Contributory Indistinctly  
Secondary(Duration) 10 yrs. .... mos. .... ds.

(Signed) James S. Bellinger, M. D.  
Nov 30, 1914. (Address) Elkton, Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL Magothy M. E. Church DATE OF BURIAL Dec 2, 1914

20 UNDERTAKER Denny & Armstrong ADDRESS Baltimore, Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

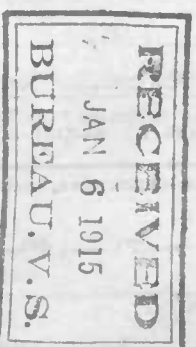
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11084

104

1 PLACE OF DEATH  
County 99.

Village or City Curtis Bay, Maryland (No. 104) St. 104 Ward 24

Registration Dist. No. 24

[It death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Julia Jefferson

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH	
3 SEX <u>Female</u>	4 COLOR OR RACE <u>N</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>	16 DATE OF DEATH <u>Nov. 19</u> , 191 <u>4</u> (Month) (Day) (Year)	
6 DATE OF BIRTH <u>Sept. 13</u> , 191 <u>4</u> (Month) (Day) (Year)			17 I HEREBY CERTIFY, That I attended deceased from <u>Oct 30</u> , 191 <u>4</u> , to <u>Nov. 19</u> , 191 <u>4</u> , that I last saw her alive on <u>Nov. 19</u> , 191 <u>4</u> , and that death occurred on the date stated above, at <u>7</u> P. m., The CAUSE OF DEATH* was as follows: <u>Chronic Gastro Enteritis</u> (Duration) <u>1</u> yrs. <u>1</u> mos. <u>0</u> ds.	
7 AGE <u>2</u> yrs. <u>6</u> mos. <u>0</u> ds. <u>1</u> day, <u>0</u> hrs. <u>0</u> min. ?			Contributory Secondary	
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Infant</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>Infant</u>			(Duration) <u>1</u> yrs. <u>1</u> mos. <u>0</u> ds.	
9 BIRTHPLACE (State or country) <u>Maryland</u>			(Signed) <u>William D. Coth</u> , M. D. <u>Nov. 19</u> , 191 <u>4</u> (Address) <u>Curtis Bay, Md.</u>	
PARENTS	10 NAME OF FATHER <u>Albert Jefferson</u>		*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.	
	11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>		18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u>0</u> yrs. <u>0</u> mos. <u>0</u> ds. In the State <u>0</u> yrs. <u>0</u> mos. <u>0</u> ds. Where was disease contracted, If not at place of death? <u>0</u> Former or usual residence <u>0</u>	
	12 MAIDEN NAME OF MOTHER <u>Eva Schultz</u>		19 PLACE OF BURIAL OR REMOVAL <u>Holy Cross Cemetery</u> DATE OF BURIAL <u>Nov. 21</u> , 191 <u>4</u>	
	13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u>		20 UNDERTAKER <u>M. Doyle &amp; Son</u> ADDRESS <u>15-C. Lee St.</u>	
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Eva Schultz</u> (Address) <u>Curtis Bay, Md.</u>				
15 Filed <u>Nov 19</u> , 191 <u>4</u> <u>J. B. Horton Md.</u> REGISTRAR				

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1 PLACE OF DEATH

11085

County

A-A-

Village or City

Annapolis - Shaw

Registration Dist. No.

21

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

John Henry Johnson

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colord 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH October 6, 1914 (Month) (Day) (Year)

7 AGE — yrs. 1 mos. 5 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Annapolis Md

## PARENTS

10 NAME OF FATHER

Horace Johnson

11 BIRTHPLACE OF FATHER (State or country)

St. Margaret. Md

12 MAIDEN NAME OF MOTHER

Bessie Robinson

13 BIRTHPLACE OF MOTHER (State or country)

Annapolis Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Horace Johnson

(Address)

Shaw st

15

Filed

Nov 13, 1914 Mrs Welch

REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Nov 11th, 1914 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct 6th, 1914 to Nov 11th, 1914

that I last saw him alive on Nov 11th, 1914

and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH\* was as follows:

Congenital Debility

Contributory Secondary

(Duration) yrs. mos. ds.

Exhaustion

(Signed)

John Ridout, M. D.

Nov 13th, 1914 (Address) Annapolis Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

Brewerhill Cemt.

DATE OF BURIAL

11. 13. 1914

20 UNDERTAKER

E. H. B. Parker &amp; Son

ADDRESS

92 West St



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

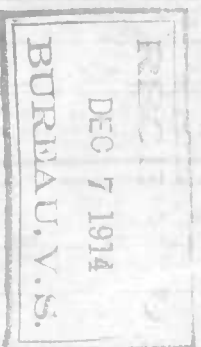
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

11086

County

Anne Arundel

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

20

Village or City

Bridgetown

(No.

St.;

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Johnnie Jones

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

Negro

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

August Sept 15, 1914

(Month)

(Day)

(Year)

7 AGE

2 yrs. 2 mos. 15 ds.

If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

None

9 BIRTHPLACE

(State or country)

Maryland

## PARENTS

10 NAME OF FATHER

Isaiah Jones

11 BIRTHPLACE OF FATHER (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Isaiah Miller

13 BIRTHPLACE OF MOTHER (State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Isaiah Jones

(Address)

Bridgetown

15

Filed

Dec 1, 1914

REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Nov 30, 1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

Nov 30, 1914, to Nov 30, 1914.

that I last saw him alive on Nov 30, 1914.

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH\* was as follows:

Cholera Infantum  
(acute milk infection)  
(Duration) yrs. mos. ds.

Contributory  
Secondary

Consciousness in feeding  
(Duration) yrs. mos. ds.

(Signed) M. D.  
Nov 30, 1914 (Address) West River, Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Daniel Staro Cemetery

Dec 1, 1914

20 UNDERTAKER

ADDRESS

Hardesty &amp; Hunt

Gallows Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Tranition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory" (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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DEC 8 1914  
BUREAU, U. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

11087

County a. asSTATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 21Village or City Annapolis (No. 15, Randall St.; 1 Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Barbara Klausky

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH June 5, 1866  
(Month) (Day) (Year)

7 AGE 48 yrs. 5 mos. 25 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work House Wife  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Lesberg Germany

10 NAME OF FATHER John Bentert

11 BIRTHPLACE OF FATHER (State or country) Lesberg Germany

12 MAIDEN NAME OF MOTHER Barbara Sengel

13 BIRTHPLACE OF MOTHER (State or country) Lesberg Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Isidor Klausky

(Address) 15 Randall St

15 Filed Dec 2, 1914 W. S. Welch

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov. 30th, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 19th, 1914 to Nov 30th, 1914.

that I last saw her alive on Nov 30th, 1914

and that death occurred on the date stated above, at 8:45 a.m.

The CAUSE OF DEATH\* was as follows:

Cancer of Uterus

(Duration) several yrs. mos. ds.

Contributory Cancer Secondary

(Duration) several yrs. mos. ds.

(Signed) Phon. Parnis, M. D.

Dec 2, 1914 (Address) Annapolis, Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

St Mary's Cemetery DATE OF BURIAL 12/3, 1914

20 UNDERTAKER

B & Hopping & Co ADDRESS 118 Cathedral St

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

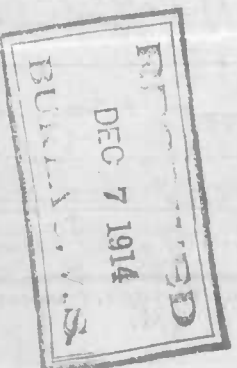
[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as accidental, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH **11088**  
County Ann Arundel

Village or City Annapolis (No. \_\_\_\_\_)

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 22

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Louise C. Layton

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH May 21<sup>st</sup>, 1887  
(Month) (Day) (Year)

7 AGE 63 yrs. 5 mos. 17 ds. If LESS than 1 day, \_\_\_\_\_ hrs. OR \_\_\_\_\_ min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work Music Teacher  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) MD

10 NAME OF FATHER George Layton  
11 BIRTHPLACE OF FATHER (State or country) Germany  
12 MAIDEN NAME OF MOTHER Sophie Seiler  
13 BIRTHPLACE OF MOTHER (State or country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Sophie K. Layton  
(Address) MD

15 Filed Nov-8<sup>th</sup> 1914 L. H. B. Haskins  
Local REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 7<sup>th</sup>, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Aug. 3<sup>rd</sup>, 1914 to Nov 7<sup>th</sup>, 1914  
that I last saw her alive on Nov 7<sup>th</sup>, 1914  
and that death occurred on the date stated above, at 11:20 p. m.

The CAUSE OF DEATH\* was as follows:

Carcinoma of Liver  
(Duration) \_\_\_\_\_ yrs. 8 mos. \_\_\_\_\_ ds.

Contributory \_\_\_\_\_  
Secondary \_\_\_\_\_  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) Intention, M. D.  
Nov 8<sup>th</sup>, 1914 (Address) Lavaca, MD

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
Where was disease contracted, If not at place of death?  
Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Evangelical Cemetery DATE OF BURIAL Nov 10<sup>th</sup>, 1914  
20 UNDERTAKER Fisher & Phair ADDRESS Laurel MD

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicaemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED  
DEC 5 1914  
BUREAU V. S.

11089

## 1 PLACE OF DEATH

County Ar. Ar. esSTATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 21Village or City Armapolis Md (No. 144, South St.; 2 Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME James H. Lee

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widower  
(Write the word)6 DATE OF BIRTH Nov 5, 1845  
(Month) (Day) (Year)7 AGE 69 yrs. — mos. 18 ds. OR LESS than 1 day, — hrs. — min. ?8 OCCUPATION  
(a) Trade, profession, or particular kind of work Laborer  
(b) General nature of industry, business, or establishment in which employed (or employer)9 BIRTHPLACE (State or country) A. A. County MdPARENTS  
10 NAME OF FATHER Unknown  
11 BIRTHPLACE OF FATHER (State or country) Unknown  
12 MAIDEN NAME OF MOTHER Unknown  
13 BIRTHPLACE OF MOTHER (State or country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Emma McCullough  
(Address) 144, South Street15 Filed Nov 26, 1914 James Welch  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH November 23, 1914  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from October 10, 1914, to November 22, 1914,  
that I last saw him alive on November 22, 1914.and that death occurred on the date stated above, at 8:30 A. M.  
The CAUSE OF DEATH\* was as follows:Carcinoma of lower jaw  
(Duration) — yrs. 4 mos. — ds.Contributory  
Secondary(Signed) Ambrose Garcia, M. D.  
11. 24, 1914 (Address) Armapolis Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)  
At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.Where was disease contracted, If not at place of death?  
Former or usual residence.19 PLACE OF BURIAL OR REMOVAL Brewer Hill Cemetery DATE OF BURIAL Nov 25, 1914  
20 UNDERTAKER Samuel Allen ADDRESS 32. N. W. St

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

V. S. No. 1.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plaster, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reverter wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## 1 PLACE OF DEATH

County

Anne Arundel

Village or City

Linthicum Heights

## 2 FULL NAME

Matilda Phelps Linthicum

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

Single

6 DATE OF BIRTH

Nov 30, 1840

7 AGE

74 yrs. 11 mos. 23 ds. OR LESS than 1 day, hrs. min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

at home

(b) General nature of industry, business, or establishment in which employed (or employer)

general housework

9 BIRTHPLACE

(State or country)

Maryland

PARENTS

10 NAME OF FATHER

Herziah Linthicum

11 BIRTHPLACE OF FATHER  
(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Matilda Phelps

13 BIRTHPLACE OF MOTHER  
(State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Sarah E. Burgess

(Address)

Brooklyn Md R.F.D.

15

Filed

Nov 23, 1914

REGISTRAR

Misland

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 23

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Nov 23<sup>rd</sup>, 1914

17

I HEREBY CERTIFY, That I attended deceased from

Nov 7, 1914, to Nov 23, 1914

that I last saw her alive on Nov 23, 1914

and that death occurred on the date stated above, at Galesburg, Md.

The CAUSE OF DEATH\* was as follows:

Bronchitis Asthma

Contributory  
Secondary

(Duration) yrs. 2 weeks

(Signed)

C. E. Robinson

Nov 23, 1914 (Address) Hanover Md R.F.D.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19 PLACE OF BURIAL OR REMOVAL

Cedar Hill Cemetery

DATE OF BURIAL

Nov 23, 1914

20 UNDERTAKER

Madison Mitchell

ADDRESS

Baltimore Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

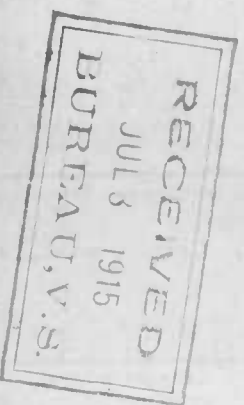
[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as accidental, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on nomenclature of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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11090

PLACE OF DEATH

County

Anne Arundel

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

25

Village or City

Brooklyn

(No.

103

Patapsco Ave.

St.

Ward)

[If death occurred in  
a hospital or institution,  
give its NAME instead  
of street and number.]

FULL NAME

Bertha M. Manthei

## PERSONAL AND STATISTICAL PARTICULARS

SEX

Female

COLOR OR RACE

White

SINGLE,  
MARRIED,  
WIDOWED,  
ORDIVORCED  
(Write the word)

Single

DATE OF BIRTH

May

(Month)

23

(Day)

1914

(Year)

AGE

5

yrs.

18

mos.

ds.

It LESS than

1 day, hrs.

OR min. ?

OCCUPATION

(a) Trade, profession, or  
particular kind of work

None

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

BIRTHPLACE

(State or country)

Anne Arundel Co

NAME OF FATHER

Herman Manthei

BIRTHPLACE OF FATHER

(State or country)

Germany

MAIDEN NAME OF MOTHER

Marie Kriemald

BIRTHPLACE OF MOTHER

(State or country)

Germany

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Herman Manthei (Father)

(Address)

103 Patapsco Ave Brooklyn

Filed

Nov 11

1914

Charles Broode

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

Nov.

10

(Month)

(Day)

(Year)

1914

I HEREBY CERTIFY, That I attended deceased from

Nov. 10

1914

to

1914

that I last saw her alive on

Nov. 10

1914

and that death occurred on the date stated above, at 3 P. m.

The CAUSE OF DEATH\* was as follows:

Broncho-pneumonia

(Duration)

abt 8

mos.

ds.

Contributory  
Secondary

(Duration)

yrs.

mos.

ds.

(Signed)

Robert P. Scheidt

M. D.

Nov. 11

1914

(Address)

1318 S. Charles St. Baltimore

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT  
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL,  
SUICIDAL, or HOMICIDAL.LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,  
OR RECENT RESIDENTS)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cedar Hill

Nov 12

1914

UNDERTAKER

ADDRESS

Armstrong &amp; Son Co

715 Light St

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

MARGIN RESERVED FOR BINDING

V. S. No. 1.

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# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

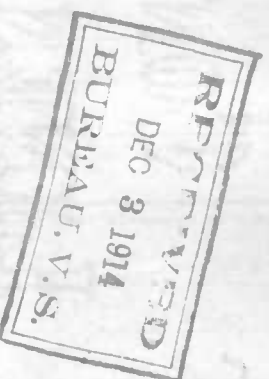
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1 PLACE OF DEATH County <u>Southwell Anne Arundel Co</u>		11569		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Annapolis</u> (No. <u>403</u> )		St.; Ward		Registration Dist. No. <u>20</u>	
2 FULL NAME <u>Mary J. Marriott</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Single</u> (Write the word)			
6 DATE OF BIRTH <u>76</u> <u>Jan.</u> <u>27</u> , 18 <u>38</u> (Month) (Day) (Year)		7 AGE <u>76</u> yrs. <u>9</u> mos. <u>5</u> ds. If LESS than 1 day, hrs. OR min. ?			
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>House work</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>at home</u>					
9 BIRTHPLACE (State or country) <u>Anne Arundel Co</u>					
PARENTS	10 NAME OF FATHER <u>Allen Marriott</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>				
	12 MAIDEN NAME OF MOTHER <u>May E. Brighton</u>				
13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>J. H. Marriott</u> (Address) <u>Annapolis Md</u>					
15 Filed <u>Nov 5</u> , 191 <u>4</u> <u>John Collinson</u> REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>Nov.</u> <u>2</u> , 191 <u>4</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from <u>Pain</u> one, 191 <u>4</u> to <u>visit Nov 2</u> , 191 <u>4</u> . that I last saw <u>her</u> alive on <u>Nov 2</u> , 191 <u>4</u> . and that death occurred on the date stated above, at <u>8 P. m.</u> The CAUSE OF DEATH* was as follows: <u>Was dying when I arrived</u> <u>to treat as my knowledge</u> <u>cause of death was Gastritis</u> (Duration) _____ yrs. _____ mos. _____ ds.					
Contributory Secondary (Duration) _____ yrs. _____ mos. _____ ds.					
(Signed) <u>John Collinson</u> , M. D. <u>Nov 5</u> , 191 <u>4</u> . (Address) <u>South River Rd</u>					
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. to the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, If not at place of death? Former or usual residence _____					
19 PLACE OF BURIAL OR REMOVAL <u>Davidsonville</u>				DATE OF BURIAL <u>Nov. 4</u> , 191 <u>4</u>	
20 UNDERTAKER <u>Jan. J. Cox Davidsonville</u>				ADDRESS	

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

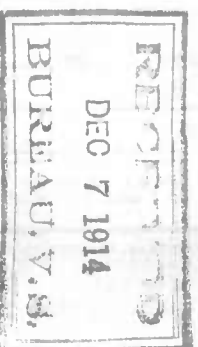
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## 1 PLACE OF DEATH

County

11091  
*Anne Arundel* (137)

Village or City

*Patuxent*—(No. ...., St.; .... Ward)

## 2 FULL NAME

*Mary Elizabeth Matthews*STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. *22*

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Female*

4 COLOR OR RACE

*Colored*5 SINGLE,  
MARRIED,  
WIDDED,  
OR DIVORCED  
(Write the word)*married*

6 DATE OF BIRTH

*November 8, 1875*  
(Month) (Day) (Year)

7 AGE

*39* yrs. .... mos. *3* ds. OR *1* day, .... hrs. If LESS than 1 day, .... min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

*House-wife*

(b) General nature of industry, business, or establishment in which employed (or employer)

*House-work*

9 BIRTHPLACE

(State or country)

*Maryland*

PARENTS

10 NAME OF FATHER

*Pompey Hebron*11 BIRTHPLACE OF FATHER  
(State or country)*Maryland*

12 MAIDEN NAME OF MOTHER

*Mary Ellen Tyler*13 BIRTHPLACE OF MOTHER  
(State or country)*Maryland*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*Henrietta Gardner*

(Address)

*Patuxent—Md.*

15

Filed

*Nov. 12, 1914*  
*L. H. 2. Haskins*  
*Local*

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

*November 11, 1914*  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

*November 4, 1914, to November 11, 1914*that I last saw her alive on *November 11, 1914*and that death occurred on the date stated above, at *9 P.* m.

The CAUSE OF DEATH\* was as follows:

*Puerperal Septicæmia*(Duration) .... yrs. .... mos. *5* ds.Contributory  
Secondary*Rupture of uterine wall*during parturition. (Duration) .... yrs. .... mos. *7* ds.

(Signed)

*R. A. Hammond*

M. D.

*Nov. 12, 1914* (Address) *Jeessup Ind.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Home Cemetery**Nov. 14, 1914*

20 UNDERTAKER

ADDRESS

*Fisher & Phair, Laurel Ind.*

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-theia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Scutle," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

DEC 5 1914

BUREAU, V. S.

**N. B.—**Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

George P French	Lansel m d
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# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

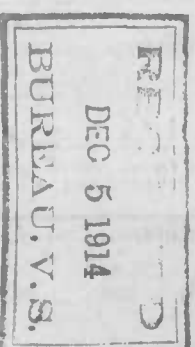
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1 PLACE OF DEATH

11093

County

A-A-

Village or City

Annapolis

(No.

71

North West

Registration Dist. No.

21

St.

Ward

4

[If death occurred in a hospital or institution, give his NAME instead of street and number.]

2 FULL NAME

Daisy Landrell Mitchell

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Colord

5 SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED

(Write the word)

Widow

6 DATE OF BIRTH

Feb.

9

1884

(Month)

(Day)

(Year)

7 AGE

30

7 mos.

5 ds.

If LESS than

1 day, hrs.

OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

Ladies Maid

(b) General nature of industry, business, or establishment in which employed (or employer)

Semptress

9 BIRTHPLACE (State or country)

Baltimore Md.

## PARENTS

10 NAME OF FATHER

Benedict Landrell

11 BIRTHPLACE OF FATHER (State or country)

Prince George Co Md

12 MAIDEN NAME OF MOTHER

Sophia Fletcher

13 BIRTHPLACE OF MOTHER (State or country)

Prince George Co Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Sophia L. Landrell

(Address)

71 N.W. St.

15

Filed

Nov 15, 1914

Jmgmelch

REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Nov. 14

(Month)

(Day)

1914

17

I HEREBY CERTIFY, That I attended deceased from

Nov. 14

1914

to

Nov. 14

1914

that I last saw her alive on Nov. 14, 1914

and that death occurred on the date stated above, at 5:20 PM.

The CAUSE OF DEATH\* was as follows:

Alcoholic Poison,  
Accidentally

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

P. B. Mullins

M. D.

Nov. 13,

1914.

(Address)

28 Calvert St

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

St Marys Cmt.

DATE OF BURIAL

11 17

1914

20 UNDERTAKER

E. B. Parker &amp; Son

ADDRESS

92 West St

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.



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RECEIVED  
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BUREAU. V. S.

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1 PLACE OF DEATH County <u>Anne Arundel</u> (5)		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>McKendree</u> (No. ....)		Registration Dist. No. <u>26</u>	
2 FULL NAME <u>Mitchell</u>		[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Single</u> (Write the word)	
6 DATE OF BIRTH <u>Nov. 28, 1914</u> (Month) (Day) (Year)			
7 AGE <u>0</u> yrs. <u>0</u> mos. <u>0</u> ds.		If LESS than 1 day, .... hrs. OR .... min. ?	
8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>None</u> (b) General nature of industry, business, or establishment in which employed (or employer) .....			
9 BIRTHPLACE (State or country) <u>Md.</u>			
PARENTS	10 NAME OF FATHER <u>Wesley Mitchell</u>		
	11 BIRTHPLACE OF FATHER (State or country) <u>Md.</u>		
	12 MAIDEN NAME OF MOTHER <u>Eva Froelich</u>		
13 BIRTHPLACE OF MOTHER (State or country) <u>Md.</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Wesley Mitchell</u> (Address) <u>McKendree, Md.</u>			
15 Filed <u>Nov. 28, 1914</u>		A. H. Perrie REGISTRAR	
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH <u>Nov. 28, 1914</u> (Month) (Day) (Year)			
17 I HEREBY CERTIFY, That I attended deceased from <u>Nov. 28, 1914</u> to <u>Nov. 28, 1914</u> , that I last saw him alive on ..... 191.... and that death occurred on the date stated above, at ..... m. The CAUSE OF DEATH* was as follows: <u>Unknown</u>			
Contributory ..... Secondary ..... (Duration) ..... yrs. .... mos. .... ds.			
(Signed) <u>A. H. Perrie</u> , M. D. <u>11-28, 1914</u> (Address) <u>McKendree, Md.</u>			
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.			
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death ..... yrs. .... mos. .... ds. In the State ..... yrs. .... mos. .... ds. Where was disease contracted, If not at place of death? .....			
Former or usual residence .....			
19 PLACE OF BURIAL OR REMOVAL <u>McKendree, Md.</u>		DATE OF BURIAL <u>11-28, 1914</u>	
20 UNDERTAKER <u>Wesley Mitchell</u>		ADDRESS <u>McKendree, Md.</u>	

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

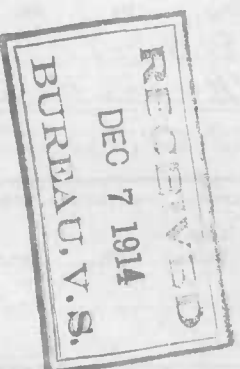
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1 PLACE OF DEATH

11095

County

Village or City

2 FULL NAME

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED  
(Write the word)

Widowed

6 DATE OF BIRTH

Nov 6<sup>th</sup>, 1838

7 AGE

76 yrs. # mos. 14 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Housework

9 BIRTHPLACE

(State or country)

Germany

PARENTS

10 NAME OF FATHER

Sebastian Rabe

11 BIRTHPLACE OF FATHER

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER

(State or country)

Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Laurence Kestlein

(Address)

Fairfield, Md

15

Filed

Nov 20<sup>th</sup>, 1914 Thos B. Horton M.D.

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Nov 20<sup>th</sup>, 1914I HEREBY CERTIFY, That I attended deceased from Nov. 16<sup>th</sup>, 1914, to Nov 20<sup>th</sup>, 1914.that I last saw her alive on Nov 19<sup>th</sup>, 1914

and that death occurred on the date stated above, at 10:30 a. m.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia

(Duration) # yrs. # mos. 4 ds.

Contributory Secondary

(Signed) Thos B. Horton M. D.  
Nov 20<sup>th</sup>, 1914 (Address) Balt. Crit. Bay

\*State the DISEASE CAUSING DEATH, or, in deaths from TRAUMA CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hollywood Cemetery Nov. 23<sup>rd</sup>, 1914

20 UNDERTAKER

ADDRESS

John J. Sheppard Balt. Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balt. Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

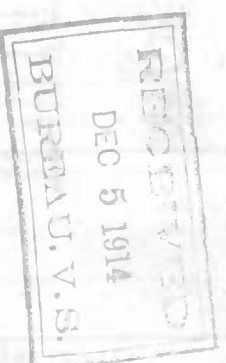
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLACE OF DEATH 11096

County

Anne Arundel

Village or City

Fair Haven

(No.

FULL NAME

William O'Neil

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

26.

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

SEX

male

COLOR OR RACE

black

SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

unknown

DATE OF BIRTH

Unknown

(Month) (Day) (Year)

AGE

50?

It LESS than  
1 day, hrs.  
OR min.?

yrs. mos. ds.

OCCUPATION

(a) Trade, profession, or particular kind of work

Seaman

(b) General nature of industry, business, or establishment in which employed (or employer)

On sail vessel

BIRTHPLACE  
(State or country)

Unknown

PARENTS

NAME OF FATHER

Unknown

BIRTHPLACE OF FATHER  
(State or country)

Unknown

MAIDEN NAME OF MOTHER

Unknown

BIRTHPLACE OF MOTHER  
(State or country)

Unknown

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Capt. Simmons

(Address)

Master of "Eugie" Baltimore

15

Filed

Nov 2 1914

Geo. J. Leonty  
Deputy Registrar

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

## MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

November 1st, 1914  
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

191 to 191

that I last saw him alive on

Dead when seen

and that death occurred on the date stated above, at

7:30 P.m.

The CAUSE OF DEATH\* was as follows:

Haemoptysis probably  
Phthisis

(Duration) yrs. mos. ds.

Contributory  
(Secondary)

Unknown (Duration) yrs. mos. ds.

(Signed) Doctor E. Howard M.D.

Nov 2, 1914 (Address) Shady Side

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL

Deale Md.

DATE OF BURIAL

Nov 2, 1914

20 UNDERTAKER

Hardesty &amp; Hunt

ADDRESS

Galloways Rd

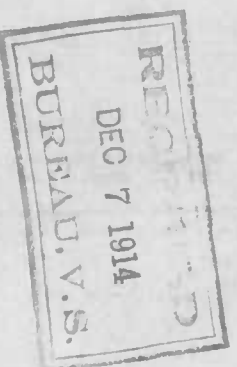
# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinster*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcinoma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Tumult," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

11097

County

A. A.

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

21

Village or City

Camp Park (No. 2<sup>nd</sup> District)

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Melissa C. Owen

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

Married

6 DATE OF BIRTH

Aug 20, 1850

7 AGE

64 yrs. 2 mos. 24 ds.

If LESS than  
1 day, hrs.  
OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE  
(State or country)

Herrington Penna

10 NAME OF FATHER

Nathaniel Morgan

11 BIRTHPLACE OF FATHER  
(State or country)

Penna

12 MAIDEN NAME OF MOTHER

Mary E. Gueon

13 BIRTHPLACE OF MOTHER  
(State or country)

Penna

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

R. J. Owen

(Address)

Annapolis R.F.D.

15

Filed

Nov 17, 1914 J. S. Welch

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

November 14, 1914

(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

Was dead to when 7, 1914

that I last saw him alive on

and that death occurred on the date stated above, at 11 P. m.

The CAUSE OF DEATH\* was as follows:

Valvular Heart Disease

(Duration) Unknown yrs. mos. ds.

Contributory  
Secondary

(Duration) Unknown yrs. mos. ds.

(Signed) Walton H. Hopkins, M. D.

November 16, 1914 (Address) Annapolis Md

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Edward Chapel Annapolis Nov 17, 1914

20 UNDERTAKER

ADDRESS

Jas. S. Taylor &amp; Sons Annapolis Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

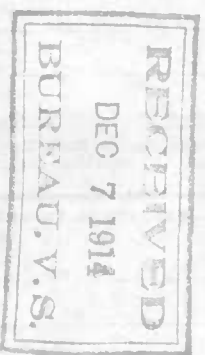
[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*, *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traema," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septichæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as accidental, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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11098

## 1 PLACE OF DEATH

County

Anne Arundel

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

2p

Village or City

Garnock

(No.

St.

Ward)

[If death occurred in  
a hospital or institution,  
give its NAME instead  
of street and number.]

2 FULL NAME

Rodolphe Owens

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,

MARRIED,

WIDOWED,

ORDIVORCED

(Write the word)

widower

6 DATE OF BIRTH

Jan 28, 1849

(Month)

(Day)

(Year)

7 AGE

65 yrs 9 mos 16 ds

If LESS than

1 day, hrs.

OR min. ?

8 OCCUPATION

(a) Trade, profession, or  
particular kind of work.(b) General nature of industry,  
business, or establishment in  
which employed (or employer)Farmer & traveling  
Salesman

9 BIRTHPLACE

(State or country)

Ind

10 NAME OF  
FATHER

Nicholas Owens

11 BIRTHPLACE  
OF FATHER

(State or country)

Ind

12 MAIDEN NAME  
OF MOTHER

Mary Welch

13 BIRTHPLACE  
OF MOTHER

(State or country)

Ind

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

James W. Owens

(Address)

Baltimore, Md.

15

Filed

Nov. 14, 1914

A. H. Terrie

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Nov. 13, 1914

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from  
April 1, 1914, to Nov. 13, 1914,  
that I last saw him alive on Nov. 11, 1914

and that death occurred on the date stated above, at 4 A. M.

The CAUSE OF DEATH was as follows:

Chronic Parenchymatous  
nephritis

(Duration) 1 yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed)

A. H. Terrie

M. D.

Nov. 14, 1914 (Address) McKendree, Ind.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT  
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL,  
SUICIDAL, or HOMICIDAL.18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,  
OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,  
if not at place of death?Former or  
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

West River Cemetery

Nov. 14, 1914

20 UNDERTAKER

ADDRESS

W. D. Welch

Bristol, Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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V. S. No. 1.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

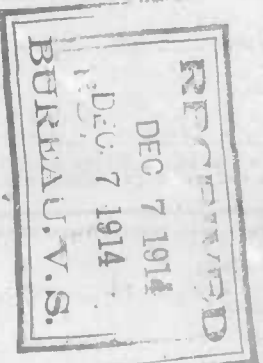
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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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11099

**1 PLACE OF DEATH**  
 County Anne Arundel (157)  
 Village or City Linthicum Heights (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2 FULL NAME** Isabelle Peterson

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Registration Dist. No. 23

**PERSONAL AND STATISTICAL PARTICULARS**

**3 SEX** Female **4 COLOR OR RACE** White **5 SINGLE, MARRIED, WIDOWED, OR DIVORCED** Single (Write the word)

**6 DATE OF BIRTH** September 1<sup>st</sup>, 1914  
 (Month) (Day) (Year)

**7 AGE** 2 yrs. 1 mos. 1 ds. OR 1 day, 1 hrs. 1 min. ? If LESS than 1 day, hrs. min. ?

**8 OCCUPATION**  
 (a) Trade, profession, or particular kind of work none at home  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

**9 BIRTHPLACE** (State or country) Maryland

**PARENTS**

**10 NAME OF FATHER** Mulford Peterson

**11 BIRTHPLACE OF FATHER** (State or country) Maryland

**12 MAIDEN NAME OF MOTHER** Rona White

**13 BIRTHPLACE OF MOTHER** (State or country) Maryland

**14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**  
 (Informant) Mulford White  
 (Address) Linthicum Heights

**15** Filed Nov 7, 1914 E. R. Winkerson  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**16 DATE OF DEATH** November 7, 1914  
 (Month) (Day) (Year)

**17 I HEREBY CERTIFY** That I attended deceased from Oct 7<sup>th</sup> 1914, to November 21<sup>st</sup> 1914, that I last saw her alive on October 21, 1914, and that death occurred on the date stated above, at 8:30 A. m.

**The CAUSE OF DEATH\* was as follows:**  
Marasmus  
of weeks  
 (Duration) \_\_\_\_\_ yrs. 1 mos. 14 ds.

**Contributory** Inability to assimilate food  
 (Duration) \_\_\_\_\_ yrs. 7 mos. 14 ds.

(Signed) E. R. Winkerson, M. D.  
Nov 7<sup>th</sup>, 1914. (Address) Hanover Md RPO

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

**18 LENGTH OF RESIDENCE** (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)  
 At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, If not at place of death? \_\_\_\_\_  
 Former or usual residence \_\_\_\_\_

**19 PLACE OF BURIAL OR REMOVAL** Friendship M. E. Cemetery **DATE OF BURIAL** Nov 9<sup>th</sup>, 1914

**20 UNDERTAKER** Wm. F. Tickner & Sons **ADDRESS** Baltimore Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

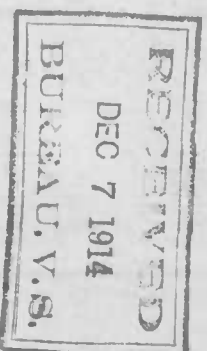
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on Nomenclature of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH <b>11100</b>		STATE OF MARYLAND	
County <b>Anne Arundel</b> <b>(42)</b>		CERTIFICATE OF DEATH	
Village or City <b>Seale</b> (No. _____) St.; _____ Ward _____		Registration Dist. No. <b>26</b>	
2 FULL NAME <b>Crisby Phipps</b>			
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <b>female</b>	4 COLOR OR RACE <b>white</b>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <b>married</b>	
6 DATE OF BIRTH <b>Aug 19, 1863</b> (Month) (Day) (Year)			
7 AGE <b>51 yrs. 3 mos. 9 ds.</b>		8 IT LESS than 1 day, _____ hrs. OR _____ min. ?	
9 OCCUPATION (a) Trade, profession, or particular kind of work <b>Sgt Home</b> (b) General nature of industry, business, or establishment in which employed (or employer)			
10 BIRTHPLACE (State or country) <b>Maryland</b>			
PARENTS			
11 NAME OF FATHER <b>Thomas H. Phipps</b>			
12 BIRTHPLACE OF FATHER (State or country) <b>Maryland</b>			
13 MAIDEN NAME OF MOTHER <b>Cinderilla Perry</b>			
14 BIRTHPLACE OF MOTHER (State or country) <b>Maryland</b>			
15 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <b>Nannie Phipps</b> (Address) <b>Church Seale</b>			
16 <b>Nov 29, 1914</b> <b>Geo. J. Dent</b> Filed _____ REGISTRAR			
MEDICAL CERTIFICATE OF DEATH			
17 DATE OF DEATH <b>Nov 28, 1914</b> (Month) (Day) (Year)			
18 I HEREBY CERTIFY, That I attended deceased from <b>July</b> , 1913, to <b>Nov</b> , 1914, that I last saw her alive on <b>Nov 27</b> , 1914, and that death occurred on the date stated above, at <b>7 A. m.</b> , The CAUSE OF DEATH* was as follows: <b>Carcinoma of uterus</b>			
(Duration) _____ yrs. _____ mos. _____ ds.			
Contributory (Secondary) _____ (Duration) _____ yrs. _____ mos. _____ ds.			
(Signed) <b>Geo. J. Dent</b> , M. D. <b>Nov 29, 1914</b> (Address) <b>Churchton Rd</b>			
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.			
19 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, If not at place of death? Former or usual residence _____			
19 PLACE OF BURIAL OR REMOVAL <b>Seale Cemetery</b>		DATE OF BURIAL <b>Nov 20, 1914</b>	
20 UNDERTAKER <b>Hardisty &amp; Hunt</b>		ADDRESS <b>Gallopway Rd</b>	

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

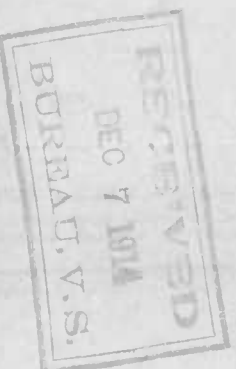
[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Anæmia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such. If impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

11101

(5)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

County

C. A.

Registration Dist. No.

24

Village or City

Curtis Bay

(No.)

St.

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Still Birth Sauchenko

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

Nov. 9<sup>th</sup>, 1914

(Month)

(Day)

(Year)

7 AGE

— yrs. — mos. — ds. OR — min. ?

If LESS than 1 day, — hrs.

8 OCCUPATION

(a) Trade, profession, or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Curtis Bay Md

PARENTS

10 NAME OF FATHER

Harry Sauchenko

11 BIRTHPLACE OF FATHER

(State or country)

Russia

12 MAIDEN NAME OF MOTHER

Augusta Dorz

13 BIRTHPLACE OF MOTHER

(State or country)

Russia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Harry Sauchenko

(Address)

1005 Curtis Ave.

15

Filed

Nov 10<sup>th</sup>, 1914

J. B. Holtz M.D.

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Nov. 9<sup>th</sup>, 1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

, 191, to , 191,

that I last saw h. alive on , 191,

and that death occurred on the date stated above, at, m.

The CAUSE OF DEATH\* was as follows:

Still Born

(Duration) yrs. mos. ds.

Contributory

Secondary

(Duration) yrs. mos. ds.

(Signed)

James H. Bowler M.D.

Nov 10<sup>th</sup>, 1914

(Address)

Brooklyn Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death yrs. mos. ds.

In the

State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Holy Cross Cemetery Nov 10<sup>th</sup>, 1914

20 UNDERTAKER

ADDRESS

John Kubliawkas 5008 Paca St.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

Balto Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

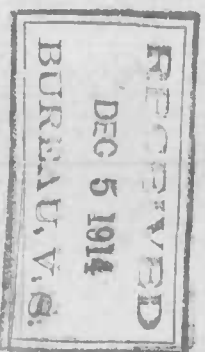
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1 PLACE OF DEATH 11102

County A. A. CountyVillage or City Annapolis (No. 140 South St.; 2 Ward)STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 21

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Catherine Sharpe

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH March 2nd, 1911  
(Month) (Day) (Year)

7 AGE 3 yrs. 8 mos. 19 ds. It LESS than 1 day, \_\_\_\_ hrs. OR \_\_\_\_ min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Annapolis Md

PARENTS  
10 NAME OF FATHER William Sharpe  
11 BIRTHPLACE OF FATHER (State or country) A. A. County Md  
12 MAIDEN NAME OF MOTHER Annie Sharpe  
13 BIRTHPLACE OF MOTHER (State or country) A. A. County Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Annie Sharpe mother(Address) 140 South St

15 Filed Nov 23, 1914 J. S. Melch  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 11 21, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov 9, 1914, to Nov 21, 1914, that I last saw her alive on Nov 20, 1914

and that death occurred on the date stated above, at 8:30 A.M.

The CAUSE OF DEATH\* was as follows:

Death Bronchitis  
(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. 21 ds.

Contributory  
Secondary

(Signed) Ambrose Garcia, M. D.  
11-23, 1914 (Address) Annapolis Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. to the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted,

If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Asbury Cemetery DATE OF BURIAL Nov 23rd, 1914

20 UNDERTAKER J. A. Adams ADDRESS Annapolis

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

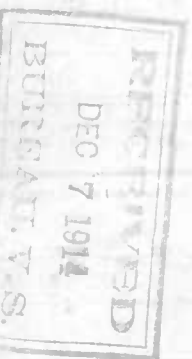
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1 PLACE OF DEATH 11103

County A-A-Village or City Annapolis (No. 9, Block Block)Registration Dist. No. 11St.; 1 Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Still Infant Stuart

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colord 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH Nov. 10, 1914  
(Month) (Day) (Year)

7 AGE — yrs. — mos. — ds. If LESS than 1 day, — hrs. OR — min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work —  
(b) General nature of industry, business, or establishment in which employed (or employer) —

9 BIRTHPLACE (State or country) Annapolis, Md.

10 NAME OF FATHER Edward Stuart

11 BIRTHPLACE OF FATHER (State or country) Annapolis Md.

12 MAIDEN NAME OF MOTHER Lousia Primms.

13 BIRTHPLACE OF MOTHER (State or country) Annapolis Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Edward Stuart

(Address) No. 9, Block, St. 1

15 Filed Nov 11, 1914 Jms Welch

REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov-10th, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov 18th, 1914, to —, 191—,  
that I last saw h — alive on —, 191—.

and that death occurred on the date stated above, at — m.  
The CAUSE OF DEATH\* was as follows:

Still-born(Duration) — yrs. — mos. — ds.Contributory  
(Secondary)(Duration) — yrs. — mos. — ds.(Signed) John Ridout, M. D.Nov 10, 1914 (Address) Annapolis Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, if not at place of death? —

Former or usual residence —

19 PLACE OF BURIAL OR REMOVAL Astbury Cemt. DATE OF BURIAL 11. 12., 1914

20 UNDERTAKER E. H. B. Parker & Son ADDRESS 92 West St



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative wealthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Anemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Irritation," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



MARGIN RESERVED FOR BINDING

V. S. No. 1.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH		11104		STATE OF MARYLAND		CERTIFICATE OF DEATH	
County <u>AA</u>		(No. <u>41</u> )		Registration Dist. No. <u>21</u>		[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
Village or City <u>Annapolis</u>		(No. <u>Corneguy Hospit</u> St.; _____ Ward)					
2 FULL NAME <u>Francis Willis Sullivan</u>							
PERSONAL AND STATISTICAL PARTICULARS							
3 SEX <u>Female</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>single</u>					
6 DATE OF BIRTH <u>July</u> (Month) <u>unknown</u> (Day) <u>1867</u> (Year)							
7 AGE <u>47</u> yrs. <u>4</u> mos. <u>-</u> ds. <u>-</u> min. ?		it LESS than 1 day, _____ hrs.					
8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)		<u>none</u>					
9 BIRTHPLACE (State or country)		<u>Ohio</u>					
PARENTS	10 NAME OF FATHER	<u>unknown</u>					
	11 BIRTHPLACE OF FATHER (State or country)	<u>unknown</u>					
	12 MAIDEN NAME OF MOTHER	<u>unknown</u>					
	13 BIRTHPLACE OF MOTHER (State or country)	<u>unknown</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE							
(Informant) <u>Corry A. Ryan</u>							
(Address) <u>Wardon A. A. Co</u>							
15 Filed <u>Nov 6</u> , 191 <u>4</u>		16 REGISTRAR <u>Jms Welch</u>					
MEDICAL CERTIFICATE OF DEATH							
16 DATE OF DEATH		<u>11</u> (Month) <u>5</u> (Day) <u>1914</u> (Year)					
17 I HEREBY CERTIFY, That I attended deceased from <u>Oct 3rd</u> , 191 <u>4</u> , to <u>Nov 5</u> , 191 <u>4</u> , that I last saw him alive on <u>Nov 5</u> , 191 <u>4</u> , and that death occurred on the date stated above, at <u>8 P</u> m.							
The CAUSE OF DEATH* was as follows: <u>Ac Cholecystitis</u> <u>Carcinoma of Intestines</u> (Duration) _____ yrs. <u>2</u> mos. _____ ds.							
Contributory Secondary (Duration) <u>2</u> yrs. _____ mos. _____ ds.							
(Signed) <u>J. J. Murphy</u> , M. D. , 191 <u>4</u> (Address) <u>Annapolis Md</u>							
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.							
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. <u>1</u> mos. <u>2</u> ds. State _____ yrs. <u>2</u> mos. _____ ds. Where was disease contracted, <u>unknown</u> If not at place of death? Former or usual residence <u>Pensacola Fla</u>							
19 PLACE OF BURIAL OR REMOVAL <u>Tallahassee Fla.</u>				DATE OF BURIAL <u>Nov 8</u> , 191 <u>4</u>			
20 UNDERTAKER <u>James S. Taylor. Son</u>				ADDRESS <u>Annapolis</u>			

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

944

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

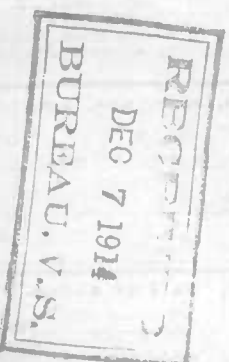
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) infection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## 1 PLACE OF DEATH

County

P. P.

Village or City

Solley a a @ 5 m d

(No.)

Registration Dist. No.

St.; Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

Tallifero (Stillborn)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Colored

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

Nov. 25, 1914  
(Month) (Day) (Year)

7 AGE

Stillborn

If LESS than 1 day, hrs. OR yrs. mos. ds. min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

None

9 BIRTHPLACE (State or country)

Maryland

PARENTS

10 NAME OF FATHER

John Tallifero

11 BIRTHPLACE OF FATHER (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Ossie Gaylor

13 BIRTHPLACE OF MOTHER (State or country)

Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John Tallifero

(Address)

Solley Md

15

Filed, 191

REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Nov. 25, 1914  
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

Nov 25, 1914, to Nov 25, 1914

that I last saw him alive on, 191

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH\* was as follows:

Stillborn

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed)

William D. Scott, M. D.

Nov. 25, 1914 (Address)

Center Gaylor

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

191

20 UNDERTAKER

ADDRESS

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

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*oma, Sarcoma, etc., of.....* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carboic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 11106 64  
 County A-A-  
 Village or City Annapolis (No. 75-Pleasant St.; 3 Ward)  
 2 FULL NAME George Edward Tasker

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Registration Dist. No. 21

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>Colored</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Widower</u>
6 DATE OF BIRTH <u>March</u> <u>unknown</u> , 18 <u>44</u> (Month) (Day) (Year)		
7 AGE <u>70</u> yrs. <u>7</u> mos. <u>—</u> ds.		it LESS than 1 day, <u>—</u> hrs. OR <u>—</u> min. ?
8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>Butcher</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>—</u>		
9 BIRTHPLACE (State or country) <u>A-A-Co. Md</u>		
PARENTS	10 NAME OF FATHER <u>George Edward Tasker</u>	
	11 BIRTHPLACE OF FATHER (State or country) <u>Annapolis Md</u>	
	12 MAIDEN NAME OF MOTHER <u>Charlottie</u>	
	13 BIRTHPLACE OF MOTHER (State or country) <u>A-A-Co Md</u>	

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Kate Tasker(Address) 75 Pleasant St15 Filed Nov 7, 1914 Wm. S. Welch

REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov. 5th, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct 31, 1914 to Nov. 5th, 1914,  
 that I last saw him alive on Nov 3th, 1914,  
 and that death occurred on the date stated above, at 5 m.  
 The CAUSE OF DEATH\* was as follows:  
Apoplexy  
Several days  
Gradual Exhaustion  
 Contributory — Secondary —  
 (Duration) — yrs. — mos. — ds.  
 (Signed) John Bidoul M. D.  
Nov 6th, 1914 (Address) Annapolis

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENCE, CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.Where was disease contracted,  
 If not at place of death?Former or  
 usual residence.

19 PLACE OF BURIAL OR REMOVAL

National Cmt.

DATE OF BURIAL

11. 8, 1914

20 UNDERTAKER

E. H. B. Parker & Son, 92 West St.

ADDRESS

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

Bidoul

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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DEC 7 1914  
BUREAU, V. S.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

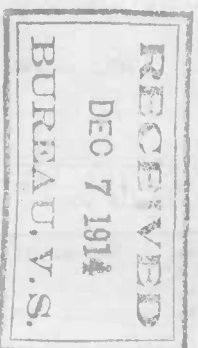
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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11108

## 1 PLACE OF DEATH

County Anne ArundelSTATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 20Village or City Bayside

(No. \_\_\_\_\_)

St.; \_\_\_\_\_ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Marshall Torque

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Jan unknown  
(Month) (Day) (Year)

7 AGE 30 yrs. unknown mos. ds. OR LESS than 1 day, hrs. min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work Farmer  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Maryland

PARENTS  
10 NAME OF FATHER Jeremiah Torque  
11 BIRTHPLACE OF FATHER (State or country) Maryland  
12 MAIDEN NAME OF MOTHER Mary Offutt  
13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Richard Male(Address) Bayside Md

15

Filed Nov 9, 1914

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 9, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from February, 1914, to Nov 9, 1914, that I last saw him alive on Oct 30, 1914

and that death occurred on the date stated above, at 8 A.M.

The CAUSE OF DEATH\* was as follows:

Diabetes Mellitis

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
Secondary Diabetes

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) Marshall Torque, M. D.  
Nov 9, 1914 (Address) Bayside Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. to the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, If not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rommel Star CemeteryNov 10, 1914

20 UNDERTAKER

ADDRESS

John ThomasBayside Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Cool mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tracema," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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DEC 8 1914

BUREAU, V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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## 1 PLACE OF DEATH

County

Village or City

(No.

St.; Ward)

## 2 FULL NAME

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

white

5 SINGLE,  
MARRIED,  
WIDDED,  
OR DIVORCED  
(Write the word)

unknown

## 6 DATE OF BIRTH

unknown

(Month)

(Day)

(Year)

## 7 AGE

about 30

yrs.

mos.

ds.

If LESS than  
1 day, hrs.  
OR min. ?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE  
(State or country)

Russia

## 10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER  
(State or country)

Unknown

## 12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER  
(State or country)

Unknown

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Byron Phelps

(Address)

Crescent

## 15

Filed

Nov 10th

1914

Holiday Affairs

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

Nov

9th

1914

(Month)

(Day)

(Year)

## 17

I HEREBY CERTIFY, That I attended deceased from

1914 to 1914

that I last saw him alive on 1914

and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH\* was as follows:

Shock. Due to coming into contact with electricity charged wire (Duration) yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) O. H. McNeer, M. D.

Nov 10, 1914 (Address) Odenton Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

## 19 PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Waterbury Md

Nov 11, 1914

## 20 UNDERTAKER

## ADDRESS

A. J. Williams &amp; Co

Waterbury

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

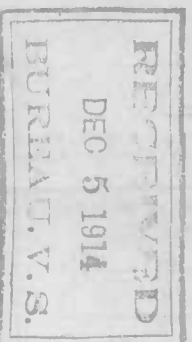
[Approved by U. S. Census and American Public Health Association.]

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*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such. If impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## 1 PLACE OF DEATH

County a

11570

189

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 20Village or City Cumberstone

(No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Chas Ward

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female4 COLOR OR RACE Colored5 SINGLE, MARRIED, WIDOWED, OR DIVORCED  
(Write the word) Married6 DATE OF BIRTH Not Known

(Month) (Day) (Year)

7 AGE 61 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

If LESS than 1 day, \_\_\_\_\_ hrs. OR \_\_\_\_\_ mo. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

## PARENTS

10 NAME OF FATHER Washington Ward11 BIRTHPLACE OF FATHER (State or country) Maryland12 MAIDEN NAME OF MOTHER Not Known13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thomas Luggs(Address) Cumberstone

15

Filed Nov 8, 1914

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 14, 1914

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov 8, 1914, to Nov 15, 1914.that I last saw him alive on Nov 15, 1914.and that death occurred on the date stated above, at 6 P m.

The CAUSE OF DEATH\* was as follows:

Cardiac paralysis  
found in fresh  
coronary embolism

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory (Secondary) Septic infection(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 10 ds.(Signed) W. R. Todd, M. D.Nov 15, 1914 (Address) Galloways

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, If not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL GallowaysDATE OF BURIAL Nov 15, 191420 UNDERTAKER W. M. TalbotADDRESS W. M. Talbot

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

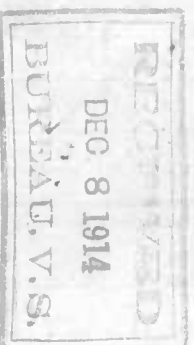
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*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmiplegia," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS or INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carboic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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11110

69

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 21

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH

County A. A.

Village or City St. Margarets (No. \_\_\_\_\_, \_\_\_\_\_ St.; \_\_\_\_\_ Ward)

2 FULL NAME

James William Waring

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH Aug. 30, 1862  
(Month) (Day) (Year)

7 AGE 52 yrs. 2 mos. 19 ds. If LESS than 1 day, \_\_\_\_\_ hrs. OR \_\_\_\_\_ min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work. Farmer  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) A. A. Co. Md.

PARENTS  
10 NAME OF FATHER Richard M. Waring  
11 BIRTHPLACE OF FATHER (State or country) Pri Geo. Co. Md.  
12 MAIDEN NAME OF MOTHER Victoria Arnold  
13 BIRTHPLACE OF MOTHER (State or country) A. A. Co. Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Mrs Jas. W. Waring  
(Address) St. Margarets A. A. Co. Md.

15 Filed Nov 20, 1914 Wm. S. Welch  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 19<sup>th</sup>, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov 19<sup>th</sup>, 1914 to Nov 19<sup>th</sup>, 1914.

that I last saw him ~~her~~ alive on \_\_\_\_\_, 191\_\_\_\_\_

and that death occurred on the date stated above, at 4 a m.

The CAUSE OF DEATH\* was as follows:

Apoplexy sudden death  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
Secondary

(Signed) Oliver Morris, M. D.  
Nov 19, 1914 (Address) Annapolis, Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
Where was disease contracted, If not at place of death?  
Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Arnolds A. A. Co. Md. DATE OF BURIAL Nov. 20, 1914

20 UNDERTAKER Jas S. Taylor, Sons ADDRESS Annapolis Md.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

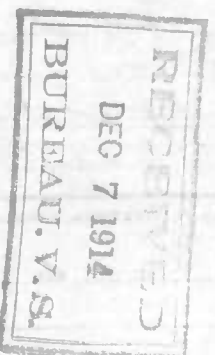
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH <b>11111</b>		STATE OF MARYLAND	
County <b>Anne Arundel</b> <b>(S)</b>		CERTIFICATE OF DEATH	
Village or City <b>Shady Side</b> (No. <b>Washington</b> )		Registration Dist. No. <b>26</b>	
2 FULL NAME <b>Washington</b>		[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
PERSONAL AND STATISTICAL PARTICULARS		MEDICAL CERTIFICATE OF DEATH	
3 SEX <b>male</b>	4 COLOR OR RACE <b>Black</b>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) <b>Infant</b>	
6 DATE OF BIRTH <b>Nov. 26, 1914</b> (Month) (Day) (Year)		16 DATE OF DEATH <b>Nov. 26, 1914</b> (Month) (Day) (Year)	
7 AGE <b>did not breathe</b> yrs. mos. ds. <b>It LESS than 1 day, —hrs. OR —min. ?</b>		17 I HEREBY CERTIFY, That I attended deceased from <b>Nov 26, 1914</b> to <b>Nov 26, 1914</b>	
8 OCCUPATION (a) Trade, profession, or particular kind of work <b>Infant</b> (b) General nature of industry, business, or establishment in which employed (or employer) <b>—</b>		that I last saw him <b>Dead on arrival</b> , 1914	
9 BIRTHPLACE (State or country) <b>Shady Side, Md</b>		and that death occurred on the date stated above, at <b>6 P</b> m.	
10 NAME OF FATHER <b>George Washington</b>		The CAUSE OF DEATH* was as follows: <b>Stillbirth about 6 months</b> (Duration) yrs. mos. ds.	
11 BIRTHPLACE OF FATHER (State or country) <b>Virginia</b>		Contributory (Secondary) <b>—</b>	
12 MAIDEN NAME OF MOTHER <b>William Hollan</b>		(Signed) <b>Forster C. Howard</b> , M. D. <b>Nov. 26, 1914</b> (Address) <b>Shady Side Md</b>	
13 BIRTHPLACE OF MOTHER (State or country) <b>Maryland</b>		*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.	
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <b>William Hollan</b> (Address) <b>Shady Side Md</b>		18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence <b>—</b>	
15 Filed <b>Nov. 27, 1914</b> <b>Geo. J. Leont Jr.</b> <b>deputy local REGISTRAR</b>		19 PLACE OF BURIAL OR REMOVAL <b>St Paul's Cemetery</b> DATE OF BURIAL <b>Nov 27, 1914</b>	
16		20 UNDERTAKER <b>Lick Scott</b> ADDRESS <b>Shady Side</b>	

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

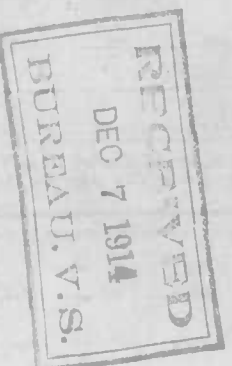
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plaster, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not painstakingly employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc. *Carcin-*

*oma, Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Insanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicaemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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11112

## 1 PLACE OF DEATH

County

Anne Arundel

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

20

Village or City

Bayards

(No. \_\_\_\_\_)

St.; \_\_\_\_\_ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

John Thomas Watkins

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

negro

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

single

6 DATE OF BIRTH

May

7

1913

(Month)

(Day)

(Year)

7 AGE

yrs. 5

mos. 24

ds.

if LESS than  
1 day.....hrs.  
OR.....min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Maryland

PARENTS

10 NAME OF FATHER

Calvert Watkins

11 BIRTHPLACE OF FATHER  
(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Bessie Crawford

13 BIRTHPLACE OF MOTHER  
(State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Thomas Watkins

(Address)

Bayards

15

Filed

Nov 1, 1914

M. C. Crawford M.D.

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Nov

1

1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

Oct 5

1914

to

Nov 1

1914

that I last saw him

alive on

Oct 28

1914

and that death occurred on the date stated above, at

1 A m.

The CAUSE OF DEATH\* was as follows:

Marasmus

(Duration)

yrs.

mos.

ds.

Contributory  
Secondary

weak feeding

low vitality

(Duration)

yrs.

mos.

ds.

(Signed)

M. C. Crawford, M. D.

Nov 1, 1914

(Address)

West Ave. Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_

to the

State

yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_

Where was disease contracted,  
if not at place of death?Former or  
usual residence

19 PLACE OF BURIAL OR REMOVAL

Horse Creek

DATE OF BURIAL

Nov. 2, 1914

20 UNDERTAKER

John Thomas

ADDRESS

Lodman Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.



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*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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DEC 8 1914  
BUREAU, V. S.

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11113

## 1 PLACE OF DEATH

County Anne ArundelVillage or City Bayard (No. \_\_\_\_\_, \_\_\_\_\_ St.; \_\_\_\_\_ Ward)STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 20

[It death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Martha Ellen Watkins

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX 7 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH Oct 6 6 1914  
(Month) (Day) (Year)

7 AGE \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 27 ds. 27 If LESS than 1 day, \_\_\_\_\_ hrs. OR \_\_\_\_\_ min. ?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

## 9 BIRTHPLACE (State or country)

Maryland

## PARENTS

## 10 NAME OF FATHER

Thomas Watkins

## 11 BIRTHPLACE OF FATHER (State or country)

Maryland

## 12 MAIDEN NAME OF MOTHER

Mary Virginia Paulk

## 13 BIRTHPLACE OF MOTHER (State or country)

Maryland

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Thomas Watkins

(Address)

Bayards, Md

## 15

Filed

Nov 2 1914Mariam Cawood

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH November 1, 1914  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from Oct 29, 1914, to Nov 1, 1914.that I last saw alive on Oct 30, 1914.and that death occurred on the date stated above, at 5:10 m.

The CAUSE OF DEATH\* was as follows:

Marasmus

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

## Contributory Secondary

Feeding, weak digestion, organs

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) Mariam Cawood, M. D.Nov 2, 1914 (Address) West River, Md

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## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, If not at place of death?

Former or usual residence

## 19 PLACE OF BURIAL OR REMOVAL

Horse Creek, Calvert Co

## DATE OF BURIAL

Nov 2, 1914

## 20 UNDERTAKER

John Thomas

## ADDRESS

Beltsville, Md

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1 PLACE OF DEATH

11114

County

A-A-

Village or City

Annapolis

(No.

145 St John's

Registration Dist. No.

21

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Thomas Harrison Watkins

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colord

5 SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word)

Married

6 DATE OF BIRTH

Nov. 9

1887

(Month)

(Day)

(Year)

7 AGE

27

yrs.

mos.

ds.

If LESS than

1 day, hrs.

OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

waiter

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Annapolis Md.

## PARENTS

10 NAME OF FATHER

George Watkins

11 BIRTHPLACE OF FATHER (State or country)

Prince George Co. Md.

12 MAIDEN NAME OF MOTHER

Alice Watkins

13 BIRTHPLACE OF MOTHER (State or country)

Annapolis Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Alice W. Cully

(Address)

145 St. John's St.

15

Filed

Nov 13, 1914

J. M. Welch

REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Nov

11

1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

Aug 10

1914

to Nov 10

1914

that I last saw him

alive on

Nov 10

1914

and that death occurred on the date stated above, at 8 A m.

The CAUSE OF DEATH\* was as follows:

Acute Septicemia

(Duration)

yrs. 3

mos. — ds.

Contributory (Secondary)

(Duration)

yrs. —

mos. — ds.

(Signed)

Ambrose Garcia, M. D.

11. 13

1914

(Address)

Annapolis Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs.

mos.

ds.

to the

State

yrs.

mos.

ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Brewerhill Cemt.

11. 14.

1914

20 UNDERTAKER

ADDRESS

E. B. Parker &amp; Son

92 West St

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

Garcia

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death.**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc.. *Carcin-*

*oma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

11115

119

County

aa

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

21

Village or City

Lumantown

(No.)

86

Spa Road

St.

Ward)

[It death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Annie Wells

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Colored

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED

Widow  
(Write the word)

6 DATE OF BIRTH

Dec

18

1898

(Month)

(Day)

(Year)

7 AGE

55

10

mos.

28

ds.

It LESS than

1 day, hrs.

OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Unknown

10 NAME OF FATHER

Unknown

PARENTS

11 BIRTHPLACE OF FATHER (State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (State or country)

Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ella Young

(Address)

105 North West St  
Annapolis Md

15

Filed

Nov 19

1914

Wm. Welch

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Nov 17th

1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

Oct 14th

1914

to

Nov 17th

1914

that I last saw her alive on

Nov 17th

1914

and that death occurred on the date stated above, at

11:00

m.

The CAUSE OF DEATH\* was as follows:

Acute Nephritis  
Several weeks

(Duration)

yrs.

mos.

ds.

Contributory

Secondary

Memoria Exhaustion  
Gradual

(Duration)

yrs.

mos.

ds.

(Signed)

John Ridout

M. D.

Nov 19th 1914 (Address) Annapolis Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Brewer Hall

Nov 19 1914

20 UNDERTAKER

ADDRESS

Geo. D. Taylor, Son

Annapolis Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

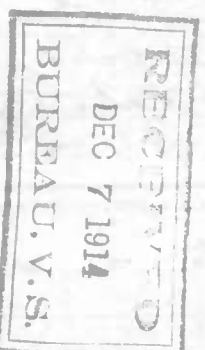
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH			11116		STATE OF MARYLAND		CERTIFICATE OF DEATH	
County <u>C. C. Co</u>					Registration Dist. No. <u>24</u>			
Village or City <u>Brooklyn</u>			(No. <u>1</u> )		St.; Ward)		[It death occurred in a hospital or institution, give its NAME instead of street and number.]	
2 FULL NAME <u>Ernest L Williams</u>								
PERSONAL AND STATISTICAL PARTICULARS								
3 SEX <u>Male</u>	4 COLOR OR RACE <u>Colored</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>	16 DATE OF DEATH <u>Nov 16</u> , 191 <u>4</u> (Month) (Day) (Year)					
6 DATE OF BIRTH <u>June 4</u> , 1902 (Month) (Day) (Year)			17 I HEREBY CERTIFY That I attended deceased from <u>Oct 24</u> , 191 <u>4</u> , to <u>Nov 16</u> , 191 <u>4</u> , that I last saw him alive on <u>Nov 15</u> , 191 <u>4</u> , and that death occurred on the date stated above, at <u>10 a. m.</u> The CAUSE OF DEATH* was as follows: <u>Typhoid Fever</u>					
7 AGE <u>17</u> yrs. <u>5</u> mos. <u>13</u> ds. OR <u>17</u> mo. ?			18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u>17</u> yrs. <u>5</u> mos. <u>13</u> ds. In the State <u>17</u> yrs. <u>5</u> mos. <u>13</u> ds.					
8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) <u>None</u>			Contributory (Secondary) <u>Hemorrhage of bowels</u>					
9 BIRTHPLACE (State or country) <u>Brooklyn a. a. Co.</u>			(Signed) <u>Thomas B. Lott</u> , M. D. <u>Nov 19</u> , 191 <u>4</u> (Address) <u>So. Balto. Md</u>					
PARENTS	10 NAME OF FATHER <u>George W. Williams</u>		*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.					
	11 BIRTHPLACE OF FATHER (State or country) <u>a. a. Co. Md</u>		19 PLACE OF BURIAL (Name of place) <u>Williams Burying Ground</u>					
	12 MAIDEN NAME OF MOTHER <u>M. Jackson</u>		20 UNDERTAKER <u>Armstrong, Henry B</u>					
13 BIRTHPLACE OF MOTHER (State or country) <u>a. a. Co.</u>		14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. <u>Geo. W. Williams</u> (Informant) <u>Brooklyn a. a. Co. Md</u> (Address)		DATE OF BURIAL <u>Nov 19</u> , 191 <u>4</u>		ADDRESS <u>75 Light St.</u>		
15 Filed <u>Nov 19</u> , 191 <u>4</u>		16 REGISTRAR <u>T. B. Lott</u>		17		18		
If more blanks are needed, address State Registrar, 3 E. Franklin St., Balto., Requesting V. S. No. 1.								

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

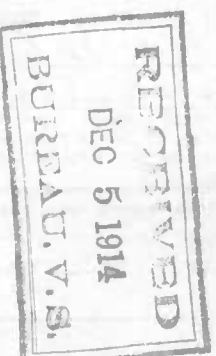
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*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Delirium" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

11117

County

Anne Arundel

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

21

Village or City

Crownville State Hospital

(No.)

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Lula Williams

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Black

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

Married

6 DATE OF BIRTH

Unknown

1878

(Month)

(Day)

(Year)

7 AGE

56

yrs.

Unknown

If LESS than  
1 day.....hrs.  
OR.....min. ?

8 OCCUPATION

(a) Trade, profession, or  
particular kind of work

Housework

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

9 BIRTHPLACE

(State or country)

Georgia

10 NAME OF  
FATHER

Allen Hurd

11 BIRTHPLACE  
OF FATHER

(State or country)

Georgia

12 MAIDEN NAME  
OF MOTHER

Susan Loftan

13 BIRTHPLACE  
OF MOTHER

(State or country)

Georgia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Hospital Records

(Address)

15

Filed

11/26

1914

J. B. Joyce

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

November 23

1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

May 13

1913

to November 23, 1914

that I last saw her

November 23, 1914

and that death occurred on the date stated above, at 4:59 a.m.

The CAUSE OF DEATH\* was as follows:

Chronic Interstitial Nephritis

(Duration)

Unknown

Contributory  
Secondary

Uremic Coma

(Duration)

3 yrs. 3 mos. 3 ds.

(Signed)

J. B. Joyce

Nov 23, 1914

(Address)

Crownville Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

1 yrs. 6 mos. 10 ds.

In the

State

Unknown

Where was disease contracted,

If not at place of death?

Unknown

Former or  
usual residence

Anne Arundel County

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hospital Cemetery

Nov. 25, 1914

20 UNDERTAKER

ADDRESS

R. T. Winkler

Crownville Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con- genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Maras-mus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæ-mia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For vio-lent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—acci-dent*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomencla-ture of the American Medical Association.)

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RECEIVED

DEC 7 1914

BUREAU, V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH 11118  
County Anne Arundel

Village or City Friendship (No. \_\_\_\_\_)

2 FULL NAME Charles Wells

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 26

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED widower  
(Write the word)

6 DATE OF BIRTH Not Known, 1849  
(Month) (Day) (Year)

7 AGE 65 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. OR LESS than 1 day, \_\_\_\_\_ hrs. \_\_\_\_\_ min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work Farm Hand  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

9 BIRTHPLACE (State or country)  Md

10 NAME OF FATHER Charles Wells

11 BIRTHPLACE OF FATHER (State or country)  Md

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (State or country)  Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thomas Thompson  
(Address) Friendship

15 Filed Nov. 22, 1914 A. H. Perrie  
Local REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Novem 24<sup>th</sup>, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov 7, 1914, to Nov 21, 1914.

that I last saw him alive on Nov 15, 1914.

and that death occurred on the date stated above, at 1145 P M.

The CAUSE OF DEATH\* was as follows:

Appendicitis  
General peritonitis

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 7 ds.

Contributory Exhaustion  
Secondary

(Signed) Compton Wilson, M. D.

Nov 22, 1914. (Address) Friendship

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, If not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Friendship, Md. DATE OF BURIAL Nov. 23, 1914

20 UNDERTAKER Art. J. Wood ADDRESS Friendship, Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmiplegia," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH <b>11119</b>		STATE OF MARYLAND	
County <u>Anne Arundel</u>		CERTIFICATE OF DEATH	
Village or City <u>Masonville</u> (No. <u>189</u> )		Registration Dist. No. <u>24</u>	
2 FULL NAME <u>William Lesta Wolf</u>		[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>	
6 DATE OF BIRTH <u>Oct. 21</u> , 19 <u>13</u> (Month) (Day) (Year)			
7 AGE <u>1</u> yrs. <u>12</u> mos. <u>12</u> ds.		If LESS than 1 day, hrs. <u>      </u> OR min. <u>      </u> ?	
8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)			
9 BIRTHPLACE (State or country) <u>Anne Arundel Co.</u>			
PARENTS	10 NAME OF FATHER <u>Augustus Wolf</u>		
	11 BIRTHPLACE OF FATHER (State or country) <u>Virginia</u>		
	12 MAIDEN NAME OF MOTHER <u>Edith Pearl Eades</u>		
	13 BIRTHPLACE OF MOTHER (State or country) <u>Anne Arundel Co.</u>		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Edith Pearl Wolf</u> (Address) <u>Masonville, G. D. Co., Md.</u>			
15 FILED <u>Nor. 2<sup>n</sup></u> , 19 <u>14</u> <u>T. B. Horton</u> M.D. REGISTRAR			
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH <u>Nov. 2</u> , 19 <u>14</u> (Month) (Day) (Year)			
17 I HEREBY CERTIFY, That I attended deceased from <u>Oct. 21<sup>st</sup></u> , 19 <u>13</u> , to <u>Nov. 2</u> , 19 <u>14</u> , that I last saw him alive on <u>Nov. 1<sup>st</sup></u> , 19 <u>14</u> , and that death occurred on the date stated above, at <u>7 A. M.</u> , The CAUSE OF DEATH* was as follows: <u>Malnutrition</u>			
Contributory (Duration) <u>5</u> yrs. <u>5</u> mos. <u>5</u> ds. Secondary <u>Pneumonia in May preceding</u> (Duration) <u>14</u> yrs. <u>14</u> mos. <u>14</u> ds. (Signed) <u>Geo. B. Davis</u> , M. D. <u>Nor. 2<sup>nd</sup></u> , 19 <u>14</u> (Address) <u>Center Bay, Md.</u>			
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.			
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u>      </u> yrs. <u>      </u> mos. <u>      </u> ds. In the State <u>      </u> yrs. <u>      </u> mos. <u>      </u> ds. Where was disease contracted, If not at place of death? Former or usual residence <u>      </u>			
19 PLACE OF BURIAL OR REMOVAL <u>Cedar Hill Cem.</u>		DATE OF BURIAL <u>Nor. 5</u> , 19 <u>14</u>	
20 UNDERTAKER <u>W. H. Hays</u>		ADDRESS <u>208 E. High St.</u>	
If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.			

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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*oma*, *Sarcoma*, etc., or..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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